ARIZONA STATE PLANNING GRANT

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Prepared by the Arizona Health Care
Cost Containment System Administration

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EXECUTIVE SUMMARY

In March 2001, the State of Arizona was the recipient of a $1.16 million State Planning Grant from the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS). With a subsequent $100,000 supplemental grant in the fall of 2002, the State was very fortunate in having access to SPG monies for over three and one-half years. This grant has lent tremendous support to the State's ongoing effort to expand coverage to the uninsured in Arizona, increasing the State's ability to ensure the provision of affordable and accessible insurance to all Arizonans. The purpose of this report is to provide a summary of the State's activities conducted under the HRSA grant from March 2001 through August 31, 2004.[1]

State Planning Grant Project Goals

The SPG project was planned and overseen by the AHCCCS Administration (AHCCCSA), the State's Medicaid agency. The three and half year project consisted of two phases, each with its own distinct project goals:

Phase I. Development of General Plan for Coverage of Uninsured (March 2001 – March 2003)

This initial phase, which consumed most of the grant's resources, included the following project goals:

- Review and compile information on current health care coverage in Arizona.
- Review current approaches/best practices being used by other states.
- Through a nine-member Statewide Health Care Insurance Plan Task Force (Task Force) and with input from a Technical Advisory Committee, develop a General Plan to address coverage of the uninsured.
- Submit to HRSA a report on the results of the SPG activities by March 2002.

Phase II. Development of Specific Coverage Options (April 2003 – August 2004)

Based on the research and recommendations developed in Phase I, this phase focused on further refining the selected coverage options and included the following project goals:

- Develop strategies for expansion of Healthcare Group as a primary means for providing accessible/affordable coverage to the uninsured.

[1] AHCCCSA has recently been awarded a $150,000 continuation planning grant to develop strategies for improving and expanding Healthcare Group's ability to offer affordable small group employer coverage to Arizona's working uninsured. The activities completed under this grant will be included in a separate report to HRSA upon the completion of the grant activities in August 2005.

- Analyze, develop and recommend additional policy options to enhance health care coverage in Arizona.
- Build ongoing support for recommended coverage options by working with key stakeholder groups such as a reconstituted Statewide Health Care System Task Force.

Data Collection

The data collection efforts which primarily occurred during Phase I were targeted at gaining an in-depth understanding of the current state of health care coverage and who the uninsured were in Arizona. AHCCCSA relied on the analysis of secondary quantitative national and state-specific data using sources such as the Current Population Survey, the Medical Expenditure Panel Survey, state surveys, and state agency data reports. Additionally, extensive qualitative information regarding coverage issues and current approaches and best practices was obtained through literature reviews and discussions with staff from other state programs and other health care experts.

For purposes of developing the selected policy options during Phase II, additional secondary data was sought and the baseline data from Phase I was continually updated. However, the secondary data often did not provide the level of detail needed to make well informed policy decisions, especially as it related to understanding the characteristics of small size firms not offering insurance. To supplement the limited quantitative data, AHCCCSA gathered qualitative data through a series of different stakeholder interviews (rural self-insured employers, rural providers and small size business groups interested in Healthcare Group).

Development of Policy Options to Increase Coverage

A key component of the project was the education of policymakers through the synthesis of information, collection of data, and preparation of briefing papers and formal presentations. In addition to reports on health care coverage in Arizona, over a dozen different policy papers were prepared by expert consultants on a myriad of topics, e.g. high-risk pools, international approaches, and rural initiatives. These papers were reviewed and discussed by the Task Force and played an important role in the establishment of a set of guiding principles and the development of the General Plan. Additional input on coverage options was also obtained from the Technical Advisory Committee and through public testimony by key stakeholder groups at Task Force meetings.

In December 2002, the Task Force adopted a General Plan that targeted four basic strategies:

- Narrow the gap between existing public and private health coverage programs.
- Restructure current state employee and retiree health care coverage programs.
- Enhance existing public supported programs.
- Improve the rural health care infrastructure through a variety of strategies including development of a plan to more effectively coordinate current rural health care resources and programs.

In developing this plan, the Task Force recognized that any expansion options that required state funds would not be feasible at this time and that a concerted effort would need to be made to maintain the recent coverage expansions such as 100% FPL and parents of Medicaid/SCHIP children.

During Phase II of the project, AHCCCSA continued to refine and/or implement strategies that supported the coverage options set forth in the General Plan. Two options that were a specific focus of SPG project were:

- Healthcare Group, a state-operated insurance plan for small businesses. In addition to modifications made as a result of Task Force recommendations in Phase I, further enhancements were needed if Healthcare Group was to become a viable insurance option for the uninsured. To accomplish this, a business plan was developed, analysis of the current HCG program and health care insurance marketplace was conducted and meetings were held with various interest groups to discuss proposed product designs and issues of affordability. Legislation was passed this May to provide HCG with the flexibility it will need to actualize the strategies set forth in its business plan.

- Premium Assistance Program, a public-private coverage program for Title XIX/XXI working families with access to employer-sponsored coverage. After conducting a feasibility study which identified some serious limitations with this option due to federal regulations and restrictions, AHCCCSA designed a premium assistant program to be piloted in two rural counties. This proposal is currently under review by the Center for Medicare and Medicaid and may not be implemented if coverage of parents with Medicaid/SCHIP children is not continued beyond July 2005 by the State Legislature.

Recommendations to Other States and Federal Government

AHCCCSA found the project organizational structure to be very effective for supporting the grant's purpose by allowing for active legislative involvement as well as valuable input from key stakeholders and health care experts. Due to the complex nature of the subject matter, education of the Task Force members as well as the public proved to be a critical component for developing the framework for future decisions regarding coverage strategies. Lastly, to support this effort AHCCCSA was able to effectively draw from secondary data and information available nationally and locally, avoiding a state specific data collection effort which can be both costly and time consuming. However, with the further refinement of coverage options, the ability to make informed decisions on specific design components and implementation strategies has been hampered in some instances by the lack of specific primary data.

The Federal Government must work in close partnership with the states in addressing the issue of the uninsured. To support the states in their efforts to expand coverage, the Federal Government should:

- Allow states more flexibility in the design and operation of Medicaid and SCHIP.

- Provide federal financial support for coverage expansions.
- Expand the level of state specific information collected by the federal government.
- Continue to fund state research on the uninsured.
- Support phase-in approaches as a realistic method for expanding coverage to the uninsured.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

This section provides an overview of how the Arizona Health Care Cost Containment System Administration (AHCCCSA) approached the issue of studying the uninsured and summarizes the resulting baseline information on the uninsured in Arizona.

Approach to Studying Uninsured

Phase I: Development of General Plan for Coverage of Uninsured

In order to develop an understanding of the uninsured in Arizona, AHCCCSA, decided initially to rely on secondary data instead of primary data collected via a special statewide survey or through focus groups. Despite certain data limitations (e.g., lack of county level data), it was felt reliance on secondary data sources (e.g., the Current Population Survey, the Medical Expenditure Panel Survey) would provide the necessary information to allow policymakers to develop a general plan for addressing health care coverage in Arizona. AHCCCSA also planned to use national studies and other states' data surveys to support and enhance the secondary data collected as many study findings show fairly consistent patterns in terms of health coverage demography and coverage issues. The high cost and long length of time were key factors in opting not to undertake the collection of primary data. AHCCCSA wanted to also be able to use State Planning Grant (SPG) monies for the gathering of information on other states' experiences, development of educational materials on health coverage issues and analysis of proposed coverage options.

AHCCCSA contracted with the University of Arizona, College of Public Health, Rural Health Office, Southwest Border Rural Health Research Center (referred to as RHO) to collect and analyze information on:

- Population characteristics and employer composition at both the State and county-level.
- Available health care coverage options in Arizona.
- Characteristics of Arizona's uninsured population.

This effort resulted in three documents - *Health Care Coverage in Arizona: An Overview, Health Care Coverage in Arizona: Data Book* and *Health Care Coverage in Arizona: Full Assessment*. AHCCCSA also contracted with Mercer, Inc. to develop a policy issue paper on key uninsured sub-populations in Arizona. In *Faces of the Uninsured and State Strategies to Meet Their Needs* Mercer identified four (4) key uninsured sub-population groups (i.e., low-income uninsured, working uninsured, rural uninsured, ethnic uninsured) that due to their size merited a closer look by policymakers as they craft solutions to health coverage. These reports were shared and

discussed with the Statewide Health Care Insurance Plan Task Force and the Technical Advisory Committee.[2]

The study approach adopted for Phase I of the project proved to be successful in that the State was able to achieve its initial project goals: educating policymakers about coverage issues and the uninsured in Arizona and facilitating the development of a General Plan for the coverage of the uninsured in Arizona.

Phase II. Development of Specific Coverage Options

Although AHCCCSA believes it was the correct decision to use secondary data collection during Phase I of the project, this same approach proved not to be as useful in the subsequent development of specific coverage options. For purposes of developing the selected policy options for coverage expansion, additional secondary data was sought and the baseline data was continually updated. However the secondary data simply was not able to provide the level of detail that was needed to make well-informed decisions as to how best to design and implement agreed upon coverage strategies. For example, in determining the best rural counties to implement a premium assistance pilot program, there was no available data on the number of uninsured in each county and so "other factors" often closely tied to the number of uninsured were examined instead (e.g., % of low-income persons in each county). Trying to develop small group products for low-income individuals proved to be more of a challenge as there was limited information available on the characteristics of the working uninsured employed at small size firms at either a state level or regional/county level.

For Phase II, AHCCCSA believes it would have been more beneficial for the State to engage in some primary data collection. Since the State was able to more clearly define the avenues it wanted to pursue in terms of coverage expansion, primary data collection efforts could be more effectively targeted. Unfortunately, resources were not available to pursue this type of activity during this phase.

Description of the Uninsured in Arizona

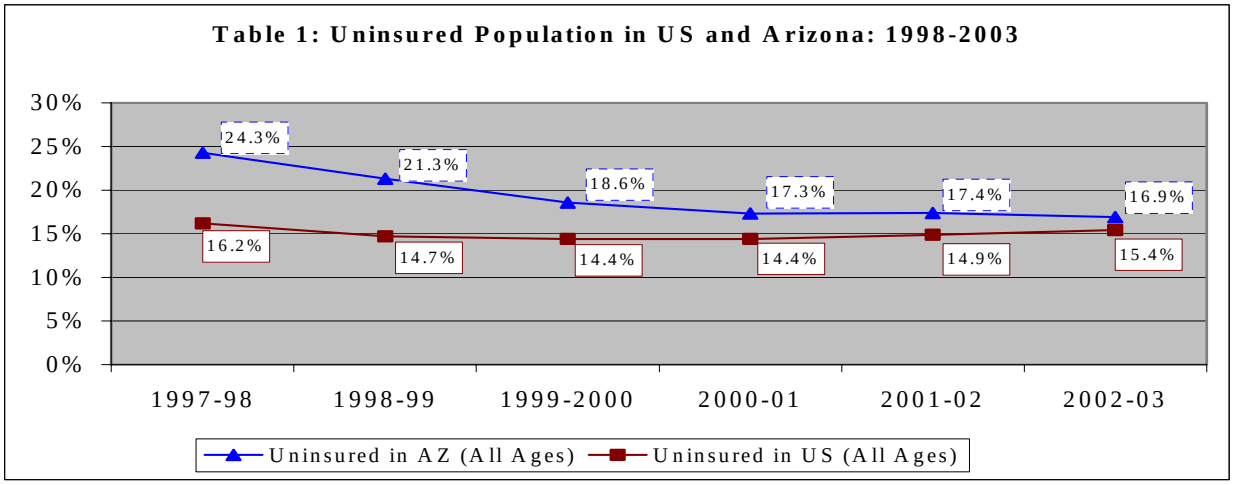
Overall Level of Uninsurance

According to the U.S. Census Bureau 2004 Current Population Report, Arizona's overall rate of uninsurance is 16.9%[3]. After decreasing substantially between 1998 and 2000, the number of uninsured in Arizona for all ages appears to have reached a plateau (see Table 1). Relative to other states, Arizona's ranking has slowly continued to improve, from having the second highest number of uninsured to now having the tenth worst record. The RHO attributes the sharp

[2]Copies of these reports can be found on the AHCCCS-HRSA State Planning Grant website at http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp.

[3] This is based on a 2 year average 2002 – 2003. See *Health Insurance Coverage: 2003 Consumer Income.* Current Population Reports by Robert J. Mills from U.S. Census Bureau (Issued August 2004); available from www.census.gov.

improvement beginning in 1998 to the increase in employer-based health insurance driven by the State's strong economy and the variety of strategies employed by the State to increase both private and public health care coverage. While the State continued to expand public coverage after 2000, these efforts may have been somewhat mitigated by the downturn of the economy and the rise in unemployment. The recent Current Population Report found that Arizona's median income between 2002-2003 and 2001-2002 has declined by 3.8%.



General Characteristics of Uninsured

Some of the key characteristics defining Arizona's uninsured population are described below. Most of the original RHO data has been updated for purposes of this section, using pooled 2001 – 2002 Current Population Survey (CPS) data from the Kaiser Family Foundation State Health Facts Online. Any significant changes in the data from that collected initially and/or reported in the March 2002 SPG Report to U.S. Health and Human Services (HHS) are noted. It is important to note this data does not reflect the impact the recent coverage expansions (e.g., adults with incomes up to 100% of FPL and parents of Title XIX/XXI children) have had on the characteristics of the uninsured.

- Income: Those with income below 200% of FPL were more likely to be uninsured than higher income persons. Sixty-seven percent of the non-elderly uninsured (ages 0-64) resided in family units with incomes below 200% of FPL (previously reported at 74%).

- Age: Among the non-elderly uninsured, under one-third were children (28.9%). Overall, children had a lower rate of uninsured than adults 19 to 64 years of age (17% vs. 21% in 2001-2002). The rate of uninsured for the population under 18 years of age has decreased substantially from 26.3% in 1998 to 14.6% in 2003[4]. Those ages 18 to 24 were more likely to be uninsured than any other non-elderly age group. The pre-Medicare age group

[4] U.S. Census Bureau. *Health Insurance Coverage Status and Type of Coverage by State: Children Under 18: 1987 to 2003*. www.census.gov/hhes/hlthins/historic/hihistt5.html.

(i.e., 55-64) that was initially a focus of policymakers was found to represent only 7% of the uninsured with the lowest rate of uninsured among the age bands.[5]

- Gender: Mirroring closely the U.S. non-elderly population, a larger proportion of males (55%) than females (45%) made-up the non-elderly uninsured population in Arizona.

- Family Composition: For the HIFA waiver proposal, AHCCCSA used merged CPS data from 1998 to 2000 and found that three-quarters of the uninsured low-income population (i.e., below 200% of FPL) represented children and parents (54% and 22%, respectively). For the remaining 24% who were adults without children, 57% were below 100% of FPL. With the recent coverage expansions under Title XIX/XXI, many of these uninsured individuals may have now been determined AHCCCS eligible.

- Health Status: While specific data on the health status of the uninsured in Arizona was not collected, several recent reports lend support to the contention that Arizona's uninsured are likely to have poorer health status due to their limited access to health services. The 1999-2000 National Health Interview Survey data found that in the Phoenix Metropolitan Area, 31.1% of the population below 200% of FPL had no usual source of care with 40.4% having no physician visit in the past year.[6] The Annie E. Casey Foundation's Kids Count Data book ranked Arizona 45th in the overall well-being of its children.[7] This ranking took into consideration such factors as mortality, family composition, adequacy of income and educational attainment. In addition, the 2003 United Health Foundation's composite index of states ranked Arizona 32nd in the nation in terms of its overall health status, taking into consideration both risk factors (e.g., violent crime, lack of health insurance) and health outcome measures (e.g., mortality, disease prevalence).[8]

- Employment Status: The majority of the non-elderly uninsured in Arizona were "working uninsured". Seventy-four percent of the uninsured were in a family unit with at least one full-time worker and 10% were in a family unit with at least one part-time worker.

- Availability of Private Coverage (including offered but not accepted): Specific information on the number of uninsured who had access to private coverage was not collected. Eighty-seven percent of Arizona employees work for private sector establishments offering health insurance with 74% of them eligible for health insurance; of those eligible, 82% have enrolled in coverage.[9] Overall, 55% of Arizonans have employer-based coverage. The rate of employer-based coverage was much lower, when one looks at it in terms of the key drivers of uninsurance: 27% for non-elderly with incomes below 200% of FPL, 45% for Hispanics, and 38% for part-time workers. Mercer's report found uninsurance rates in Arizona increased as firm size decreased (e.g.,

[5] From Mercer, Inc analysis presented to Statewide Health Care Insurance Plan Task Force on September 27, 2001.
[6] *Monitoring the Health Care Safety Net: Book I A Data Book for Metropolitan Areas,* Agency for Healthcare Research and Quality, 2003.
[7] *Kids Count 2004 Data Book Online.* Ann E. Casey Foundation. http://www.aecf.org.
[8] United Health Foundation, America's Health: State Health Rankings – 2003 Edition. http://www.uhf.org.
[9] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2002 Medical Expenditure Panel Survey – Insurance Component. www.meps.ahrq.gov.

45% uninsurance rate for firms of less than 10 employees to 19% for firms of 1,000 or more employees).[10]

- Availability of Public Coverage: Specific information on the number of uninsured who had access to public coverage but were not enrolled was not collected. The percentage of Arizonans on AHCCCS today is 17%, with the percentage nearly doubling (primarily due to eligibility expansion) since 1998 when it was at 9%. During the Technical Advisory Committee deliberations, Mercer estimated 50% of the current uninsured population could be covered through public-funded programs if they applied.

- Race/Ethnicity: A disproportionate number of uninsured were Hispanics who, while comprising only one-quarter of the total State population, represented approximately half of Arizona's non-elderly uninsured. Additionally, the rate of uninsured was much higher among non-elderly Hispanics (33%) than any of other racial/ethnic groups in the State (i.e., Non-Hispanic White at 12%, African-American at 21% and all others at 23%).[11] Mercer noted that there was a lack of detailed uninsurance data on the Hispanic uninsured in Arizona but looking at national data indicates that low-income is a key driver affecting the Hispanic uninsured with many working for small size employers who do not offer health care benefits.

- Immigration Status: Specific information on the immigration status of the uninsured was not collected. Not surprising, as a border state, Arizona, has a higher percentage of non-citizens (11%) than the overall US population (7%). The Kaiser Family Foundation reported that nationally between 42% and 51% of non-citizens lack health coverage compared to 15% of native citizens.[12]

- Geographic Location: Fifteen percent of Arizona's population resides in a non-metropolitan area of the state. Similar to national trends, RHO found rural residents (27.2%) in Arizona were uninsured at a higher rate than urban residents (23.9%) in 1999. While specific data on the number of uninsured by counties was not available, AHCCCSA examined key drivers of uninsurance and found rural counties in Arizona often had higher unemployment rates with a higher percentage of low-income residents and a lower average median family income. The Mercer issue brief *Initiatives to Improve Access to Rural Health Care Services* noted that rural uninsured tended to be employed by small-employers, reside in households with at least one full-time worker, are older, younger and poorer and have fewer provider network choices.

- Duration of Uninsurance: Specific information on the duration of the uninsured was not collected. The Kaiser Family Foundation reported that nationally in 2002, 53% of the

[10] Mercer, Inc. July 2001. *Faces of the Uninsured and State Strategies to Meet their Needs: A Briefing Paper*.
[11] The rate of uninsured previously reported for Hispanics in the 2002 SPG Report was 45%.
[12] Kaiser Commission on Medicaid and the Uninsured. June 2004. *Immigrants and Health Coverage: A Primer*. www.kff.org.

non-elderly uninsured lacked coverage for more than 12 months, 25% for 6 to 11 months and 22% for less than 6 months.[13]

Key Uninsured Sub-Populations

The Mercer policy issue paper, *Faces of the Uninsured and State Strategies to Meet Their Needs* was invaluable in demonstrating how the uninsured population is not a single, homogeneous population but is comprised of a number of smaller sub-populations, formed by several key drivers of uninsurance which include age, employment (status and firm size), income (relative to poverty level), ethnicity and geography (urban vs. rural) including:

- Low-Income Uninsured, especially low-income uninsured children and their parents.
- Ethnic Uninsured, especially low-income Hispanics uninsured.
- Working Uninsured, especially working uninsured in small size firms.
- Rural Uninsured, especially rural low-income uninsured children and their parents.

This paper, along with the information compiled by RHO was critical in helping to guide policymakers' efforts in selecting coverage expansion approaches to be included in the General Plan. In addition to supporting public expansion efforts targeted at the low-income uninsured, the General Plan recommended specific strategies targeted at the working uninsured in small size firms and the rural uninsured.

In addition to the four groups set forth by Mercer, policymakers also expressed interest in two other sub-populations:

- Initially, the Statewide Health Care Insurance Plan Task Force identified the uninsured pre-retirement group as a sub-population they were concerned about due to constituent inquiries. This group became of less interest to policymakers after Mercer presented information to the Task Force members showing that Arizonans ages 45 to 64, while representing 19% of the non-elderly uninsured population in Arizona, generally had higher incomes than the Arizona population as a whole.
- The Technical Advisory Committee felt it was important to focus on the sub-population of uninsured individuals who were eligible for public funded programs but were not enrolled. As a result, the need for outreach to eligibles was included in the plan.

Other Qualitative Findings on the Uninsured

Factors Contributing to the Lack of Health Care Coverage

RHO and Mercer's analysis of Arizona's health care marketplace identified a number of key factors contributing to the rate of uninsured. These included:

[13] Kaiser Commission on Medicaid and the Uninsured. January 2004. *Lack of Coverage: A Long-Term Problem for Most Uninsured.* www.kff.org.

- Lower-income workers, especially those who work part-time, cannot afford health insurance premiums.
- Lack of adequate income to continue coverage under employment-based health plans after involuntary layoffs (i.e., COBRA).
- Smaller firms are less likely to offer insurance.
- Populations eligible for public programs do not know that they are eligible and do not know how to become eligible.
- Changes in immigration laws have made it more difficult for public advocates to find and enroll eligible populations in AHCCCS due to factors such as fear of deportation, cultural and language barriers.
- A belief that insurance is not necessary, e.g., the "Superman" effect resulting from the young healthy populations who see themselves as indestructible and feel health insurance coverage is not necessary.

Additionally, for residents in rural areas of the State who have an increased risk of uninsurance compared to their urban counterparts, the ability to access and receive adequate health care is made more difficult due to three (3) fundamental barriers:

- A critical lack of physicians and other providers.
- Geographic isolation.
- Hospital solvency.

The impact of these "rural barriers" is reflected in the fact that, of Arizona's 15 counties, three (3) entire counties are federal Medically Underserved Areas (MUA), a measure that includes both provider shortages and poorer health outcomes. Additionally a substantial portion of ten (10) other counties are designated as a MUA.

Affordability

In *Arizona Basic Health Benefit Plan: A Comprehensive Review*, Mercer noted that if the premium levels of the Basic Plan are set equal to the average cost of insurance available on the small-group market, a price generally available to the uninsured population already, then the plan will likely not be effective in meeting the financial needs of the uninsured. More reasonable comprehensive benefit designs will not be affordable to low-income uninsured without the use of significant subsidies by employers, state agencies or other sources. As illustrated through case studies presented in the paper, for someone at 200% of FPL, the typical premium and costs of deductibles and coinsurance can exceed 20% of the family's income. The issue of affordability was also reinforced through the input AHCCCSA obtained from discussions with HCG members and other involved stakeholders.

Role of Safety-Net for the Uninsured

As in other states a significant level of health care and other related services are delivered to the uninsured through a core set of safety-net providers. In Maricopa County, it was estimated that 38% of individuals served in 2000 by primary care safety-net providers were uninsured. The safety-net providers include public and privately supported hospital systems, community health centers or clinics, local health departments, individual practitioners and other health care entities. These providers are supported through federal, state, local and private dollars. Due to limited resources, the safety-net providers clearly do not meet all the health care needs of these populations. In particular, specialty care, including dental and behavioral health care, which has been cited as the missing piece of the safety-net puzzle.[14]

Arizona has approximately 35 community health centers (13 of which are federally qualified health centers) with over 100 satellites and with a patient mix that consists of 32% uninsured.[15] When compared to the nation, Arizona has a low number of Bureau of Primary Health Care supported clinics per 100,000 population under 200% of FPL (3.2 vs. 5.2 nationally).[16] Also unlike other states, Arizona only has two publicly owned hospitals – settings that historically have provided significant amounts of the much-needed care to the uninsured. In addition to receiving federal support, the State allocates a limited amount of state generated tobacco tax monies to support safety-net providers. This amount has decreased in recent years due to increases in funds needed for Medicaid and decreasing tobacco tax revenues. A survey conducted by the Arizona Hospital and Health Care Association found that $387 million in uncompensated care was provided in 29 hospitals in 2001 with $306 million in bad debt and $81 million in charity care. According to the State Health Access Data Assistance Center (SHADAC) State Health Access Profile, however, Arizona's uncompensated care spending per population under 200% of FPL was much lower than the national average ($136 per population under 200% of FPL vs. $245 nationally).

[14] *Squeezing the Rock: Maricopa County's Health Safety-net* Arizona Health Futures, St. Luke's Health Initiatives. Winter 2002; available from http://www.slhi.org/ahf/studies.
[15] Arizona Association of Community Health Centers November 26, 2001 presentation to the State Health Care Insurance Plan Task Force.
[16] SHADAC State Health Access Profile: Arizona. http://www.shadac.org/analysis/stateprofiles.asp#A.

SECTION 2. EMPLOYER-BASED COVERAGE

This section provides an overview of how AHCCCSA approached the issue of studying the state of employer-based coverage in Arizona. A summary of the resulting baseline information gathered on employer-based coverage in Arizona is provided including the characteristics of Arizona's business environment and of those employers who opt to provide coverage.

Approach to Studying Employer-Based Coverage

Phase I: Development of General Plan For Coverage of Uninsured

Understanding employer-based coverage was included as a component of the analysis undertaken as part of the RHO study on health care coverage in Arizona. (See Section 1 of this report for a more in-depth discussion regarding the study approach). For this component of the their study the RHO drew upon data from Agency for Health Care Research and Quality, Center for Cost and Financing Studies, 1996-1999 Medical Expenditure Panel Survey (MEPS) – Insurance Component, Arizona Department of Economic Security, Research Administration and U.S. Census Bureau. The information gathered on employer-based coverage is contained in the three RHO documents - *Health Care Coverage in Arizona: An Overview, Health Care Coverage in Arizona: Data Book* and *Health Care Coverage in Arizona: Full Assessment*.[17] Additionally, AHCCCSA also gathered some qualitative information from previous small group employer surveys.

These documents were shared and discussed with both the Statewide Health Care Insurance Plan Task Force and Technical Advisory Committee. Through this study approach, the State was able to achieve its initial project goals by educating policymakers about employer-based coverage and its relationship with uninsurance in Arizona and facilitating the development of a General Plan for coverage of the uninsured in the State.

Phase II: Development of Specific Coverage Options

For purposes of developing the selected policy options, additional secondary data was sought and the baseline data was continually updated. However, as discussed under Section 1, the secondary data often did not provide the level of detail needed to make well informed policy decisions, especially as it related to understanding the characteristics of small size firms not offering insurance. To supplement the limited quantitative data, AHCCCSA gathered qualitative data through a series of different stakeholder interviews (rural self-insured employers, rural providers and HCG members and related stakeholder groups.

[17] Copies of these reports can be found on the AHCCCS-HRSA State Planning Grant website at http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp.

Description of Employer-Based Coverage

Arizona's Business and Employment Environment

In 2003, the leading industries and occupations in Arizona were similar to the rest of the United States in that:[18]

- Education, health and social services; and retail trade were the two ranking industries in terms of employment at 19% and 13% respectively.
- 78% of the people employed were private wage and salary workers, 16% were government workers and 6% were self-employed.
- The three most common occupations were: management, professional and related occupations (34%); sales and office occupations (27%); and service occupations (18%).

Where Arizona's business environment differs from the rest of the U.S. is in the greater role construction (9% vs. 7% in US) and the leisure and hospitality (10% vs. 8%) industries play over manufacturing (9% vs. 12% in the US). This is not unexpected given Arizona's rapid growth with its continual demand for new housing and its draw as a tourist destination.

Of the 101,318 private-sector firms in Arizona, approximately three-fourths of them (73%) had fewer than 50 employees.[19] The smallest firms, those with fewer than 10 employees, comprised 55.5% of all firms in Arizona, while large firms, those with 1,000+ employees, comprised 15.3% of all firms. However, of the 1,848,147 employees, only 11.7% of all employees work for the firms with less than 10 employees while 46.7% work for the firms with 1,000+ employees.

Although the statewide unemployment rate in Arizona was lower than the national average in 2003 (5.6% vs. 6.0%), the State's median household income was only $40,762 (vs. US average of $43,349) with 15% of the population below 100 % of FPL (vs. 13% for the US).[20] Arizona ranks 21st among the states in 2002 in average wage per job ($33,704).[21]

General Description of Employer-Based Coverage in Arizona

The description of employer-based coverage in Arizona provided in this section has been updated from the original information compiled by RHO. Most of the information provided is from the 2002 Medical Expenditure Panel Survey – Insurance Component. Any significant changes in the data from that which was collected initially and/or reported in the March 2002 SPG Report to HHS are noted.

[18] U.S. Census Bureau. *American Community Survey Profile 2003*. http://www.census.gov/acs.
[19] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2002 Medical Expenditure Panel Survey – Insurance Component. www.meps.ahrq.gov.
[20] U.S. Census Bureau. *American Community Survey Profile 2003*. http://www.census.gov/acs.
[21] Arizona Department of Economic Security, Research Administration. http://www.workforce.az.gov.

Overview

Historically, a lower percentage of Arizonans have been covered by employer-based coverage than the rest of the US.[22] In 2003, 54.8% of Arizonans (vs. 60.4% for the U.S.) had employer-based coverage. The percentage of Arizonans covered through employers had steadily increased from a low in 1996 of 50.3% to a high in 2000 of 59.1%, but declined once again with the downturn in the economy. While the nation as a whole reflected a similar trend, it was not as marked as it was in Arizona.

The same trend as described above for the percentage with employer-based coverage can be seen in the number of private-sector employers who offer health insurance (see Table 2 below). In 2002, 52.4% of private-sector employers in Arizona offered health insurance as oppose to 57.2% nationally.

Table 2. Arizona Private-Sector Employers Who Offered Health Insurance by Firm Size: 1996 - 2002

Year	Total	Less than 10 Employees	10 – 24 Employees	25 – 99 Employees	100 – 999 Employees	1,000 or More Employees
1996	55.1%	32.9%	72.6%	73.5%	78.9%	88.6%
1997	53.2%	31.3%	50.0%	87.7%	100%	99.2%
1998	53.7%	32.8%	59.6%	78.4%	96.3%	95.5%
1999	58.8%	35.7%	65.9%	83.9%	96.2%	99.4%
2000	62.9%	43.9%	64.3%	85.2%	91.9%	100.0%
2001	58.9%	37.6%	57.3%	81.5%	96.0%	100.0%
2002	52.4%	28.4%	60.9%	72.7%	94.4%	98.8%

Source: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, Medical Expenditure Panel Survey – Insurance Component.

Firms Not Offering Coverage

Some of the key characteristics of firms that do not offer coverage, as compared to firms that do is provided below.

- Employer Size (including self-employed): As reflected in Table 2 above, firms not offering health insurance tended to be those in smaller firms.[23] In 2002, 64% of the firms with less than 50 employees did not offer insurance as opposed to 4% of the firms with 50 or more employees. The percentage of small size firms not offering insurance was

[22] U.S. Census Bureau. *Health Insurance Coverage Status and Type of Coverage by State: All People: 1987 to 2003.* www.census.gov/hhes/hlthins/historic/hihistt4.html.
[23] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2002 Medical Expenditure Panel Survey – Insurance Component. www.meps.ahrq.gov

substantially higher in Arizona than in the rest of the U.S. (55%). Although data was not available on the number of persons who are self-employed in Arizona, in 2001 the total number of small businesses that filed a Schedule C (income from self employment form) was 329,548 and a Schedule F (income from farm employment) was 7,486.[24]

- Industry Sector: The 2002 MEPS data reported the following percent of private-sector establishments by industry groups not offering health insurance:

  - 52% for agriculture, fish, forestry and construction (representing 10% of all firms, 8% of employees)
  - 49% for retail/other services/unknown (representing 42% of all firms, 42% of employees)
  - 49% for professional services (representing 22% of all firms, 24% of employees)
  - 42% for mining and manufacturing (representing 4% of all firms, 7% of employees)
  - 42% for all other (representing 22% of all firms, 19% of employees)

- Employee Income Brackets: Firms with a higher percentage of low-wage employees (50% or more) were more likely not to offer insurance (61%) than those firms with fewer low-wage workers (48%). This same trend was seen when looking at percent of establishments that do not offer health insurance by wage quartiles:[25]

  - 66% in Quartile 1 (representing 38% of establishments in Arizona)
  - 47% in Quartile 2 (representing 23% of establishments in Arizona)
  - 30% in Quartiles 3 and 4 (representing 39% of establishments in Arizona)

- Percentage of Part-Time and Seasonal Workers: The fewer full-time workers the firm had the less likely the firm was to offer insurance. The percentage of firms not offering insurance was:

  - 59% of firms with less than 50% full-time employees
  - 55% with 50 to 74 % full-time employees
  - 33% with 75% or more full-time employees.

- Geographic Location: No specific data was collected. However, a survey conducted in 2000 of small size employers found firms in metropolitan areas of Arizona were more likely than those in rural areas to offer health care coverage.[26]

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[24] *Number of Businesses in Arizona.* May 2002. Published in partnership between Arizona Department of Commerce and the ASU College of Business, Center for the Advancement of Small Business.

[25] The four wage quartiles each represent 25% of the total U.S. employment for private-sector establishments. Establishments in the lowest of the four quartiles (1st quartile) have lower average payrolls per employee (compensation excluding fringe benefits) than any establishments in the 2nd quartile.

[26] WestGroup Research. *Small-Business Survey Arizona 2000* prepared for Arizona Hospital and Healthcare Association, Arizona Chamber of Commerce, Blue Cross and Blue Shield of Arizona and St. Luke's Charitable Health Trust. http://www.azhha.org/public/pdf/small_bus_full_rpt.pdf.

- Others: The MEPS data also revealed some other distinct characteristics regarding firms not offering health insurance, including:

    - Newer firms (less than 5 years) were more likely not to offer health insurance (76% vs. 46% for longer established firms in which the age of firm was 5 or more years).
    - For-profit, unincorporated firms were more likely not to offer insurance (66%) than non-profit firms at 54% and incorporated for-profits at 42%.

Firms Offering Coverage

- Costs of Policies: From 1996 to 2002, the national average single premium dollar cost per enrolled employee rose from $1,991 in 1996 to $3,188 in 2002 (60% increase). Arizona's overall premium dollar cost rose from $1,791 to $2,985 (67% increase) during this time period, falling slightly between 1998 and 1999. The average cost for a single premium in small size firms (less than 50 employees) was greater than that of larger firms ($3,275 vs. $2,923).

  During the same period 1996-2002, both the national and Arizona average family premium costs rose. However, like the single premium, the average family premium in Arizona, was consistently lower than the national average ($7,954 vs. $8,469 in 2002).

- Level of Contributions: In 2002, the percent of premiums contributed by employees enrolled in single coverage was 18.3% (or $547) and for family coverage it was 27.1% (or $2,159). While the percent contribution has not changed much since 1999, the actual dollar amount paid by the employee has increased as a result of the increase in total premium costs. The average contribution for single coverage was also slightly less in small size firms than firms with 50 or more employees (16.5% vs. 18.8%).

- Percentage of Employees Offered Coverage Who Participate: In 2002, 74.2% of employees (full and part-time) who worked for firms offering health insurance, were eligible for coverage. Of those about 81.5% of them opted to enroll in the coverage. While the number of employees who opted to participate did not change, the percentage of employees who were eligible for insurance declined from 1999 when it was at 80.7%. Availability and participation by part-time employees is much lower with only 21.1% eligible for insurance coverage through their employee and 52.1% opting to enroll in coverage. Both the percentage of part-time employees eligible for coverage and the percentage opting to enroll had declined since 1999 when 24.8% were eligible and 67.6% opted to enroll.

Other Qualitative Findings on Employer-Based Coverage

Due to policymakers' strong interest in addressing lack of coverage among small size firms, AHCCCSA, during Phase I, gleaned additional qualitative information by reviewing the results from recently conducted surveys of small size firms. This information was enhanced during Phase II through stakeholder interviews conducted by AHCCCSA in an effort to understand how Healthcare Group of Arizona (HCG) could become a viable solution for providing accessible and affordable insurance to the uninsured working in small size firms (see discussion under Section 4). The information obtained through these efforts was used in developing a new business plan for HCG to become a more effective program in reducing the number of uninsured and later on in the development of new benefit packages for the program.

Surveys of Small Size Employers

During Phase I of the project, AHCCCSA examined the results from three surveys conducted of small size employers in Arizona to understand their issues regarding purchasing of health insurance. In all the surveys affordability and accessibility of health insurance was raised as a key concern.[27] Additionally, for some small businesses the purchasing of health insurance for employees was not viewed as a key business priority. A brief overview of these surveys is provided below.

Small-Business Survey Arizona 2000: In 2000, a random telephone survey of 401 owners and managers of Arizona businesses having fewer than 50 employees was conducted by WestGroup Research for the Arizona Hospital and Healthcare Association, Arizona Chamber of Commerce, Blue Cross and Blue Shield of Arizona and the St. Luke's Charitable Health Trust.[28] The survey found that for small size businesses in Arizona, employee health was generally not seen as a primary business issue with key areas of concern being maintaining a quality workforce, meeting customer needs or governmental regulation.

Firms who offered health coverage recognized that it was important to employees and used it to attract and keep them. They would only discontinue coverage in the face of a major increase in the cost of premiums. Due to cost, half of these firms offered employee-only coverage. Of their employees who declined coverage (18.6%), it was generally because they had coverage through a spouse (41%) or they could not afford it (26%).

Firms that did not offer coverage did not see a strong link between offering a health care plan and attracting and keeping employees. It was seen as a major drain of finances; requiring a major commitment of resources. Many of these employers rejected the possibility without even investigating coverage options. These firms noted the following factors might increase the likelihood that they would offer employee health insurance:

[27] Kaiser Daily Health Policy Report from September 28, 2004 reported on a new poll completed by Behavior Research Center of 400 small businesses in Maricopa County. The survey found that only 44% of small businesses could afford to offer employee health benefits, down from 52% in 2000 and 57% in 1996.
[28] Ibid

- 25% tax credit in addition to the normal deduction (27%).
- Possibility of having a harder time getting and retaining employees (25%).
- Tax on firms that did not offer (21%).
- Competitors offered a plan (15%).
- Lower premiums (25%).

Arizona Department of Insurance: As part of a required evaluation of Arizona's Accountable Health Plan (AHP) laws, the Arizona Department of Insurance conducted an informal survey of groups representing the interests of small size business employers to find out the experiences of their members or clients in the small group health insurance market.[29] The survey responses indicated:

- Small size employers continue to experience limited access to group health insurance for reasons of both availability and affordability.
- Ongoing impediments to availability were related to administrative factors, compliance issues, product limitations and lack of competition.
- Small size employers uniformly describe affordability as the biggest access issue and perceive employee health status, prescription drugs, statutory mandates and lack of competition to be the primary affordability problems.

National Federation of Independent Business in Arizona: A survey conducted by the National Federation of Independent Business in Arizona found the cost of health care to be the top issue for small size businesses in Arizona. As a result of the survey the organization's 2002 legislative agenda recommended:

- No new state health mandates.
- Increase buying power of small-businesses by allowing them to pool together.
- Provide a health insurance income-tax credit (state and/or federal) for working uninsured.
- Create state medical savings accounts, tax-free accounts to help pay for the cost of health care that can roll over balances to future years.

[29] Arizona Department of Insurance. 2002. *Triennial Report Regarding the Accountable Health Plan Laws*.

SECTION 3. HEALTH CARE MARKETPLACE

This section provides an overview of how AHCCCSA approached studying the State's health care marketplace. Also included is a summary of the resulting baseline information that was gathered on the current health care market place in Arizona as well as other states' experiences with the implementation of coverage expansion strategies.

Approach to Studying the Health Care Marketplace

Phase I: Development of General Plan for Coverage of Uninsured

In order to develop the general plan for coverage of the uninsured, considerable energy was expended on gaining an in-depth understanding of Arizona's health care marketplace, including examining the success of coverage expansion efforts in other states. To assist with this task, AHCCCSA contracted with Mercer, Inc and Milliman USA, Inc. Based on literature reviews; discussions with staff responsible for health coverage programs in selected states and staff consultants with experience working on various programs; and analysis of local state data files, a series of issue briefs were produced. The resulting issue briefs, in turn were distributed to members of the Statewide Health Care Insurance Plan Task Force and the Technical Advisory Committee and discussed at subsequent meetings of these groups.[30]

Phase II: Development of Specific Coverage Options

In order to develop specific coverage options, more detailed information was gathered by AHCCCSA as it related to health care marketplace in rural Arizona and the current small group insurance market.

As it pertains to the rural health care marketplace, AHCCCSA conducted two separate qualitative studies involving interviewing:

- Over 90 rural practitioners throughout the State about issues and strategies related to healthcare infrastructure and the development of an accessible and affordable statewide health care system; and
- A small group of rural public-sector employers and employee benefit managers about strategies employed to keep coverage affordable and barriers faced in providing health care to their employees.

[30] These briefs are discussed later in this Section and in addition copies of these briefs can be found on the AHCCCS-HRSA State Planning Grant website at http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp

Besides sharing these reports with the Statewide Health Care Insurance Plan Task Force and other interested stakeholder groups, the information in the reports was used by:

- AHCCCSA in the development of the 2003 RFP for acute care health plans.
- University of Arizona Medical School in the development of its plan to address physician shortages in the State.
- University of Arizona, Rural Health Office in the development of a plan to improve health care in rural areas of the State.

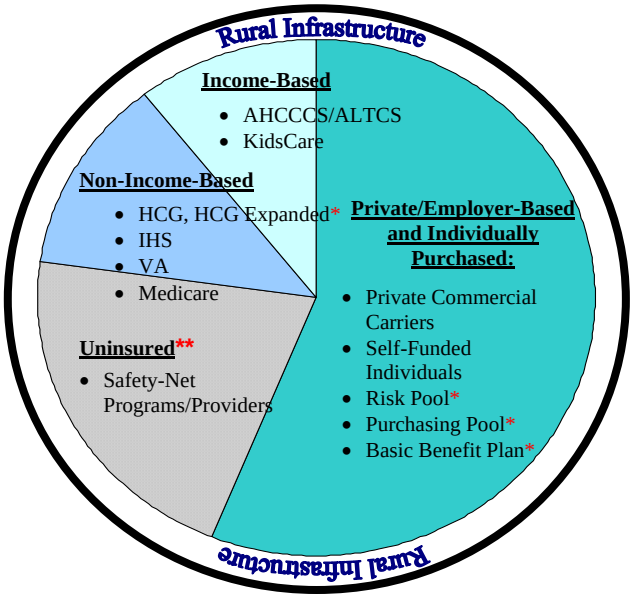
To develop benefit plans that are more marketable to small businesses, HCG researched existing benefit plans for small businesses, spoke to business and trade associations and local chambers of commerce to solicit input on the needs of the uninsured and perceived coverage barriers.

Additionally, in response to interest expressed by the Statewide Health Care Insurance Plan Task Force, AHCCCSA had Mercer analyzed the cost for small group products using a "Medicaid" benefit package. This in turn was shared with the Task Force members.

Description of Health Care Marketplace in Arizona

A general overview of health care coverage in Arizona is set forth in the following two diagrams – "Health Coverage in Arizona" (Diagram 1 below) and "Health Coverage in Arizona (Income-based)" (Diagram 3 in Appendix I). These diagrams were prepared by AHCCCSA for the Statewide Health Care Insurance Plan Task Force in order to illustrate the types of coverage and the income criteria for those publicly-sponsored programs that AHCCCSA administers.[31]

Diagram 1: Health Care Coverage in Arizona



* = Proposed Programs being considered by the Task Force
** = Uninsured Characteristics:
- Rural Areas
- Small & Medium Employers
- Low-Income (not poor)
- Early Retirees
- Eligible, but not enrolled

[31] These two diagrams have been updated to reflect the current AHCCCS eligibility categories and the current Federal Poverty Levels.

As discussed in Section 2, the majority of Arizonans are covered through employer-based coverage. As of August 2004, 972,403 Arizonans (approximately 17.3%) were covered through public-funded income-based programs (i.e., Title XIX/XXI).[32] The Center for Medicare and Medicaid (CMS) reported 769,443 Arizonans (approximately 13.7%) were enrolled in Medicare as of March 2004. In addition to publicly supported programs, the State of Arizona is one of the largest employers in the State, currently employing 36,700 individuals with approximately 70,000 employees/retirees and their dependents enrolled in the State's health care benefit program.

In Arizona, the unique tribal health care delivery system plays a more prominent role than in the health care delivery systems found in other states (over 160,000 Native Americans live on-reservations). For Arizona's 21 tribes, Indian Health Services (IHS) is the primary provider of medical care, especially on-reservation. Through self-determination some tribal nations have assumed partial or full control of medical care for respective tribal members. Given limited IHS dollars and limited availability of some services (i.e., specialty care), many tribal members are forced to travel long distances to receive needed medical care.

Recent Health Care Marketplace Trends

One consistent way in which Arizona has been able to monitor changes that are occurring to its health care marketplace is through the Center for Studying Health System Change (HSC), Community Tracking Study. Phoenix is one of 12 communities that HSC track every two years through site visits. Despite its limited geographic focus, it does provide some valuable information regarding recent trends in the State's health care marketplace, many of which are applicable statewide. In the 2003 Community Tracking Study, the following key developments were reported:[33]

- Rapid population growth and a large presence of undocumented immigrants continue to strain health care resources, creating treatment delays in area hospitals (see discussion under infrastructure).
- Hospitals are continuing to build additional full-service hospitals, competing with a growing number of physician-owned specialty facilities.
- With rising insurance premiums (rising 10 to 20% annually), employers are aggressively increasing employee cost sharing.
- Health plan financial situations have improved since 2000.[34]
- There has been a movement to open-access HMOs with broad networks and PPOs.

[32] AHCCCS Population by County August 2003 – 2004.
[33] Short, Ashley C., et. al. Summer 2003. *Population Growth, Economic Downturn Stress Phoenix's Health Care Capacity*. Community Report No 10. Center for Studying Health System Change. http://www.hschange.org/CONTENT/592.
[34] June 2004 Arizona Department of Insurance year-to date data shows 7 out of 8 HMOs were making a profit (after tax income), with one showing a profit of $15 million and one showing a loss of $1.1 million. This is in contrast to 3 years ago when 6 out of 8 HMOs were showing a loss.

Historically, Arizona had a high HMO penetration rate, but like the rest of the nation, Arizona's health care market has seen some movement away from the traditional managed care approach. Arizona's current HMO penetration rate is approximately 35%.[35] (RHO reported that the HMO penetration rate was 47.8% in 1998.) Besides employer-based coverage, managed care still plays a dominant role in the public-sector service delivery system with:

- All persons eligible for the State's Medicaid and SCHIP program (i.e., AHCCCS) receiving their health care services through one of nine capitated managed care health plans; and
- 27% of Arizona's Medicare beneficiaries enrolled in one of nine Medicare Advantage plans.

In the Department of Insurance's last evaluation of the Accountable Health Plan laws, it found that in Arizona as in other states, the small group market is shrinking.[36] The availability of group health insurance to small size employers has been adversely affected by a decease in the numbers of Accountable Health Plans. In 1999, there were 104, but as of December 31, 2001, there were 54. Of these, it was estimated that probably only 27 were active in the small group market.

Self-insured firms are becoming more prevalent in Arizona. In 2002, 33.8% (34,245) of the private-sector establishments in Arizona offering health insurance self-insured at least one health insurance plan. At that time, there were almost one-half million active enrollees in such plans.[37] This percentage has increased since 1998 when 29% (or 27,234) of the private-sector establishments self-insured at least one plan. Seen as a strategy for controlling costs and making insurance "more affordable", the following issue briefs were produced by Mercer and reviewed by the Task Force to provide a better understanding of the self-insurance model:

- *Review of Self-Insuring of Health Benefits* explains the features and differences between fully insured funding arrangements and self-insured funding, as well as minimum premium funding which is a combination of fully and self-insured.

    - Self-insurance allows employers to eliminate insurance profit and risk charges and take control of plan design with the flexibility staying with the employer. The disadvantage is that assets may be exposed to legal liability due to self-funding and monthly cash flow can fluctuate.
    - Successes of self-funded plans are linked to constant monitoring and assessment of costs and utilization, willingness to make changes when needed, selection of "best of breed" providers, targeted contracting with networks/providers for deep discounts, strong utilization and case management programs in place.

[35] Based on 2004 publication of Market Facts Output By State produced by Healthcare Computer Corp of America, Managed Care News and Strategic Information; includes members enrolled in Medicaid, Medicare Advantage and commercial HMO. http://www.hmo-info.com/mktfacts/mktfact_output.cfm?stid=1

[36] Arizona Department of Insurance. 2002. *Triennial Report Regarding the Accountable Health Plan Laws.*

[37] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2002 Medical Expenditure Panel Survey – Insurance Component. www.meps.ahrq.gov.

- *State Employee Health Plan Self-Funding Survey* looked at the approach taken by 34 state employee health benefit programs that are self-funded and found:

    - Sixty-eight percent of the states, self-fund at least one of their medical plans for state employees and five (5) more are considering self-funding.
    - Sixty-two percent fully-insure their HMOs while self-funding indemnity, PPO and other types of plans.
    - None include self-funded employee plans as part of a larger statewide health insurance reform or expansion initiatives.
    - Seventy-four percent allow other groups to participate, e.g., counties, cities, towns, political subdivisions, school districts.
    - All states contract with outside vendors to provide some type of administrative services.

Included as one of the recommendations in the General Plan developed by the Task Force is the restructuring of current state employee coverage programs through adoption of a self-insured model. In October, the State implemented a self-insured model and the City of Phoenix is currently in the process of soliciting bids to manage a similar program.

Understanding Cost Drivers and Participation Factors

One of the Task Force's main goals was to see an increase in the availability of "affordable" insurance products in Arizona. As part of Phase I of the project, a number of policy briefs were completed that examined factors perceived by Task Force members as cost drivers as well as determinants of participation in health insurance programs. A brief description of these papers is provided below:

- *Health Insurance Administrative Costs* (Mercer) discussed factors impacting administrative expenditures and provided percentages of total expenditures spent on administration by insurance plan types in 2000.

    - Typical administrative functions include claims processing, network development and maintenance, case management, actuarial services, medical management, data collection and analysis, marketing and administrative management.
    - The level of administrative expenditures is dependent on breadth of services offered, special needs of the population, size of the plan, regulatory requirements, and efficiency in administering the plan.
    - While administrative expenditures have continued to increase in recent years, they have decreased as a percent of total expenditures. For insurance plan types in 2000, the percentage of total expenditures spent on administration was 12 to 18% for indemnity or PPO, 12 to 20% for POS, 14 to 18% for commercial HMO and 10 to 21% for Medicaid HMO.

- *Financial Impact of Recently Enacted Health Insurance Mandates* (Mercer) conducted an independent cost study in order to estimate the financial impact of health insurance mandates recently enacted by the 1999 HMO reform law e.g., direct access to chiropractic services, standing referral requirement and access to medical supplies.

    - The study considered mandates in six (6) areas: administration, access to medical supplies, pharmacy, direct access to care, emergency services and clinical trials. Taken together, the estimated impact of the enacted mandates was a 5.7% increase in health care premiums.
    - Direct access to chiropractic services had the greatest cost impact at 3%.

- *Elasticity of the Demand for Health Care Services* (Mercer) discussed the relationship between the demands for health care as it relates to the cost of care, (i.e., relationship between increases in health care cost and the impact it has on the purchasing of health care and/or insurance).

    - Demand for health care is considered to be inelastic – changes in price tend to have a small impact on changes in quantity.
    - Similar to health care, overall health insurance is relatively inelastic (e.g. for every 1% increase in health care premiums there is an estimated 0.1% decrease of insured Americans).
    - The Urban Institute found that for every 1% increase in premiums as a percentage of income, there is a corresponding drop in presentation of approximately 10 %.

- *Arizona Basic Health Benefit Plan: A Comprehensive Review* (Mercer) examined the Arizona Basic Health Benefit Plan and the proposed basic plan being informally discussed among the Task Force members in the context of other states' approaches and critiques the plan in terms of benefit design variables as well as its overall affordability. The report found that the Arizona Basic Health Benefits are:

    - Not basic.
    - Not targeted at the uninsured.
    - Not affordable.
    - Not attractive since consumers are currently not showing much interest in purchasing the product.

<u>Health Care Infrastructure</u>

As reported in the Community Tracking Report, Arizona's rapid population growth is placing significant pressure on the current health care infrastructure and all its health care facilities, making it more difficult for the State to accommodate the needs of its growing population. The State is facing shortages of both professional staff as well as hospital beds. For example, the number of physicians in Arizona is 218 per 100,000 vs. a national rate of 272 and a total of 2.0

hospital beds per 1,000 vs. a national rate of 2.9.[38] The 2003 workforce shortage survey conducted by the Arizona Hospital and Healthcare Association found:[39]

- The vacancy rates for in-demand healthcare professionals (nurses, pharmacists, radiological technologists, medical technologists, and respiratory therapists) had not improved substantially since the 2001 survey.
- Employee-focused programs had been effective in reducing turnover of health care professionals (e.g., turnover rate for nurses decreased from 27% in 2001 to 15% in 2003).
- The following conditions were identified as symptoms of insufficient hospital workforce: emergency room overcrowding and diversion, reduced staffed beds, dependence on contract labor, physician dissatisfaction; closed beds, reduced outpatient capacity, delayed surgeries and increased waiting times for surgery.

There are a number of efforts currently under way in the State to try and remedy some of these shortages, e.g., increase in training/educational slots for nurses, building of new hospitals especially in rapidly growing urban centers, and increased investment in the State's telemedicine network, especially in rural areas.

Task Force members were particularly concerned about the impact these workforce shortages were having on the already fragile rural health care infrastructure and the affordability and accessibility of coverage options for rural residents – a group considered to be at increased risk for uninsurance compared to urban residents. In order to better understand both issues hindering the development of a strong rural health care infrastructure and potential strategies to consider in improving the rural healthcare marketplace, AHCCCSA reviewed the findings from the following reports with the Task Force:

- *Initiatives to Improve Access to Rural Health Care Services* (Mercer) provided an overview of strategies that had been implemented by other states to increase access to health care in rural areas both in terms of increasing coverage and enhancing provider networks.

    - Key barriers identified include: lack of physicians and other providers, geographic isolation and hospital solvency issues (i.e., insufficient volume to justify size and capabilities).
    - Strategies employed by other states to address rural infrastructure concerns and provisions including: financial and technical assistance to make rural areas more attractive to practitioners, examples of collaboration between health and non-health resources and/or urban and rural resources, changes in reimbursement methodologies for hospitals, and creative use of hospital space and resources.

[38] SHADAC State Health Access Profile: Arizona
[39] Healthcare Institute at the Arizona Hospital and Healthcare Association. October 2003. *2003 Workforce Shortage Survey*. http://www.azhha.org/public/workforce/hci.

- *Inventory of Arizona Strategies to Address Rural Health Care Infrastructure* provided a comprehensive description of specific strategies/programs that have been implemented in Arizona. These strategies were grouped according to those which:

    - Increase the number of rural practitioners.
    - Minimize geographic isolation.
    - Improve the viability of health care facilities.
    - Financially support rural-based health care service programs.

As a result of the information gained through both these reports and the information on the uninsured, the Task Force included the need to continue to develop rural health care infrastructure as one of their recommendations for addressing coverage issues in Arizona. The recommendation also included specific steps that should be taken by the State, e.g., increasing accessibility to medical services through student residency rotations and use of telemedicine networks. In an effort to support the further development of this recommendation, AHCCCSA as discussed earlier in this section, conducted two separate studies during Phase II of the project. This resulted in the following two reports

- *Rural Health Care Provider Interviews: Developing a Strong Rural Health Care Infrastructure Challenges and Successes* provided a plethora of information in the delivery of rural health care regarding issues and barriers, effective coverage strategies and needed changes and solutions.

    - Overall lack of providers in the communities including PCPs, specialists and other support practitioners.
    - Successful strategies to address recruitment and retention issues, included loan repayment, J-1 visa waiver program, income guarantee/financial assistance program, compensation and bonuses, scholarship program, and use of visiting physicians.
    - Successful strategies to support and extend productivity of rural providers included use of physician extenders, improved work environment, use of hospitalists, and specialty clinics using visiting physicians. Use of telemedicine and mobile diagnostic equipment received mixed reviews in terms of effectiveness.
    - Actions steps consistently recommended included controlling increasing malpractice rates through tort reform, providing incentives for physicians to practice in rural environments and continuing to allocate Tobacco Tax monies for primary care services.

- *Key Stakeholder Interviews of Rural Employers and Employee Benefit Specialists* examined strategies used by public-sector employers to ensure coverage is accessible and affordable and identifies barriers purchasers faced in providing health care to their employees.

- All interviewed employers, representing major purchasers of health care in rural areas were partially self-insured and felt it had allowed them to hold down their health care costs.
- Most had made recent modifications in benefit structure to address increasing health care costs, e.g. increase deductibles, copays, institute drug formulary, etc.
- Lack of provider competition and availability of specialists were a key problem in being able to offer coverage.
- High premium cost was the main reason cited for employers in their community not offering coverage to employees.
- Examples of strategies to consider included increasing provider reimbursement rates, implementing incentives for providers to practice in rural areas, and increasing size of purchasing pools.

Other States' Experiences with Coverage Expansion

Other states' and other countries' experiences with health care delivery and coverage expansion played an important role in the policy deliberation regarding health care coverage in Arizona. In order to educate policymakers regarding experiences outside of Arizona, a series of policy issue briefs were prepared by Milliman USA, Inc. and Mercer, Inc. A summary of the findings from these papers is provided below:

- *Purchasing Pools* (Milliman) focused on purchasing pools established for small-employee groups and individuals/families and their effectiveness in improving access and affordability to health insurance.

    - Historically, challenges faced by pools have involved: low employer enrollment, lack of health plan participation, unwillingness of agents to promote, adverse selection, and the inability to offer PPO and POS plans.
    - Need to substantially increase the enrollment in pools in order to be viable and be able to offer lower prices.
    - Not able to lower prices enough to encourage more small-employers to offer insurance without significant subsidies or mandates.

- *High-Risk Pools* (Milliman) examined the types of risk pools implemented by other states to cover residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market.

    - Risk pools play a major role in making coverage available to uninsurable individuals, reducing the number of uninsured and providing stability to the health care market.
    - A key issue in establishing a high-risk pool is to make sure that it is well-funded including revenue sources besides premiums and assessments.

- *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage* (Milliman) provided an overview of incentives that have been implemented by other states to increase private health insurance coverage as well as provided commentary on the effectiveness of legislative mandates at the state level.

    - SCHIP and premium sharing programs have been successful in enrolling targeted populations, although crowd-out may be a concern.
    - Tax credits and deductions are questionable for the uninsured and may be more appropriate to discuss at federal levels.
    - Small group market reform has led to stability, more readily available products and more predictable cost increases, but has not addressed the affordability issue and has had little or no impact on the number of uninsured.
    - Individual market reform has not been successful in reducing the number of uninsured.
    - Programs which are successful in reducing the number of uninsured generally involve some expenditure of public funds.

- *International Approaches to a Socialized Insurance System* (Milliman) provided a brief overview of the socialized medicine approach to the delivery of health care that has been operating in European and other select countries.

    - These systems are largely reliant on taxation, highly regulated, place a significant emphasis on preventive care, require co-pays and ration care through waiting lists.
    - To implement this type of system in U.S./Arizona, one would need significant increases in taxes to cover the uninsured, mandatory employer-based coverage, ERISA exemption, more uniformity of benefits, more regulation of provider fees, restrictions on patient choice of provider and income-based differentiation of benefits and/or contributions.

SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

This section discusses the policy options selected by the State for inclusion in the State's general plan for coverage of the uninsured and steps that have been taken to actualize these selected options. In addition, more detail information is provided about two specific options whose further development became the focus of SPG grant activities (i.e., Healthcare Group and Premium Assistance Programs/Employer-Sponsored Insurance).

Options Selected for Inclusion in General Plan for Coverage of Uninsured

The Statewide Health Care Insurance Plan Task Force was responsible for developing a General Plan for coverage of the uninsured, a plan that would ensure health insurance was accessible and affordable for all Arizonans. Three factors were instrumental in guiding the Task Force as it selected options for inclusion in the General Plan:

- A set of basic principles for health care coverage in Arizona. Through a facilitated discussion, the Task Force members developed four basic guiding principles:

  - Health care, especially basic benefits should be available and accessible.
  - Health care should be affordable and properly financed.
  - Health care should be provided through a seamless system, offering the highest quality care.
  - Health care should be done in collaboration and in cooperation with the various stakeholders, both public and private sector and it should foster competition.

  Each of these guiding principles was accompanied by a set of specific questions (criteria) that were revisited throughout the course of the Task Force's deliberations surrounding development of a plan to address accessible, affordable health care in Arizona.

- Policy issue briefs on coverage strategies and data on the uninsured and health care coverage in Arizona (see discussion in Sections 1 – 3). In addition to better understanding Arizona's specific coverage related issues, Task Force members gained insight into the effectiveness or lack of effectiveness various strategies have had on addressing the issue of accessible and affordable health insurance.[40]

- A state budget crisis. With a $1.2 billion shortfall for FY2003, Task Force members felt any options to expand coverage which required state funds would not be feasible at this

[40]Based on findings from these issue briefs, strategies such as tax credits, small employer market reform, social insurance, were eliminated as effective options for reducing the uninsured rate in Arizona.

time, although should be given consideration over the long-term. The Task Force members were also concerned about maintaining recent AHCCCS coverage expansions.

As part of its final report to the Legislature and Governor, the Task Force set forth a General Plan for providing Arizonans with accessible and affordable health insurance. This included further exploration of four broad strategies:

1. Narrow the gap between existing public and private health coverage programs through examining the feasibility of implementing:

    - Insurance reform to promote more accessible and affordable coverage options, especially those targeted at the individual and small group markets (e.g., Healthcare Group).
    - Consumer and employer education initiatives on the value of health care coverage and existing options within the private marketplace.
    - Private-public coverage programs such as a high-risk pool, full cost buy-in program or a premium assistance employee buy-in program.
    - Program for cooperative purchase of employee health care benefits by small group employers.

2. Restructure current state employee and retiree health care benefit programs (e.g., self-insurance system and expansion of pool size).

3. Enhance existing public-supported programs through:

    - Support of effective outreach programs.
    - Coverage of parents of Title XXI children expansion of coverage groups.
    - Development of a plan to expand Title XIX coverage groups through state plan amendments.

4. Improve the rural health care infrastructure through:

    - Continuing to support safety-net providers.
    - Fostering volunteerism and engaging the services of retirees from the health care professions.
    - Encouraging competition between health care service providers.
    - Increasing accessibility to medical services.
    - Developing a plan to more effectively coordinate current rural health care resources and programs.

In order to ensure further development of these options, the Task Force also recommended the Task Force be continued in statute (scheduled to expire in December 2001), changing the name of the Task Force to the Statewide Health Care System Task Force and adding three additional members (i.e., representatives from House of Representatives, Senate and University of Arizona Health Science Center).

Legislation (Laws 2002, Chapter 265) was passed in the spring of 2002 that codified the Task Force recommendations and continued the efforts of the Task Force until December 2004.

Progress on Selected Options

Since 2001, the State has continued to make progress on further refining and/or implementing strategies that support the coverage options set forth in the General Plan adopted by the initial Task Force. In addition, to lend further support to this effort, AHCCCS has included in its 2004 – 2009 strategic plan a specific goal to "reduce the rate of uninsured Arizonans by providing affordable health care coverage." Table 3 summarizes the steps the State has taken related to the various selected coverage options contained in the General Plan. A more detailed exploration is provided below for two of these selected options - HCG Enhancements and Design of a Premium Assistance Program - as further refinement of these strategies, was dependent on the use of SPG funds.

Healthcare Group Enhancements

Healthcare Group (HCG) has and continues to be an integral part of the SPG efforts. It is viewed as an important strategy for making coverage accessible and affordable to small businesses, especially for individuals who are self-employed. The challenge in both Phase I and Phase II of this project has been to develop strategies that allow the HCG program to become financially solvent and at the same time be able to offer affordable coverage to its target population.

Implemented in 1988, HCG was created to provide affordable and accessible health care coverage to small businesses with 50 or fewer employees and political subdivisions within the State. The program is administered by AHCCCSA and not subject to State insurance regulations for commercial plans. HCG's enrollment peaked in 1997 with slightly over 20,000 members. Enrollment then began to decline when the general health care market started to experience problems because of steep cost increases. In order to keep the program solvent, the Legislature began to subsidize the program (initially $8 million in 2000, decreasing to $4 million 2004).

During Phase I of the project, the ongoing viability of HCG became one of the Task Force's major concerns. Mercer conducted an analysis of HCG and presented the following findings to the Task Force:[41]

- Over a three-year period its medical costs rose 17% while premiums increased only 9%.
- The enrolled population showed features of a high-risk pool, with increasing acuity.
- HCG health plans experienced financial losses for the past three years.
- Administrative costs were above average for all HCG health plans due to low membership.

[41] *HealthCare Group – Moving Towards Accountability: A Proposed Plan.* January 2001.

In addition to the General Plan, the Task Force recommended (and supported necessary legislation in 2002) to make the following recommended changes set forth in the Mercer report.

- Transferring administrative functions (marketing, enrollment and premium pricing) back to HCG (the State).
- Implementing a single uniform benefit package.
- Gathering household income information making it possible for the State to provide subsidies to only those in need.
- Establishing risk-adjusted premiums adequate to cover medical and administrative costs.

Although the modifications made as a result of the 2002 legislation were implemented, AHCCCSA realized the goal to make HCG into a viable insurance option for the uninsured could not be achieved through these modifications. If HCG was to significantly impact the uninsured rate in Arizona, additional research and planning were necessary to develop affordable products that would be appealing to small size businesses and low-income employees.

In February 2004, AHCCCSA developed and finalized a business plan with the overall goal to significantly increase HCG membership (i.e., 12,000 to 55,000 by 2006). In particular, low-income uninsured who do not qualify for AHCCCSA would be targeted through the development of additional customized benefit packages (e.g., PPO, deductible options, and FQHC plans). In developing this plan, AHCCCSA conducted extensive analysis of the current HCG program and healthcare insurance marketplace. Meetings were held with community interest groups (e.g., Hispanic, Asian, and Afro-American business groups, local chambers of commerce, credit unions) to solicit their input on new benefit packages and issues of affordability. Additionally, input about benefit design was solicited from interested persons visiting the HCG display booth at conferences and health fairs. Examples of input received included:

- Lower rates for family coverage and/or for those who do not use the system.
- Inclusion of a rate for an employee plus children.
- Offering a benefit plan that has deductibles.
- Inclusion of behavioral health drugs and care, vision and/or dental in a benefit plan.
- Only requiring businesses to pay premiums one month in advance as opposed to the current requirement for a two-month payment.
- Changing definition of full time employee from 20 hours or more to 32-40 so that it would be easier for businesses to meet participation requirements.
- Reduction in the amount of paperwork required to apply for HCG.

These discussions allowed AHCCCSA to further refine proposed product design and better understand issues of affordability for small businesses.

Support for the new HCG business plan became critical; especially since legislation was needed in order to actualize several of the strategies set forth in the business plan. Gaining this support proved to be a challenge. Several large commercial insurers viewed this new approach as potentially encroaching on their market share. AHCCCSA made numerous presentations to key

stakeholder groups (e.g., Task Force, legislative budget committee, and commercial insurance companies). These efforts were greatly enhanced by having the support of both the Governor and Task Force members who saw further development of this program as one of the key strategies to be employed to reduce the number of uninsured in Arizona. After much negotiation, legislation was finally passed in May that included the following:

- Allows HCG to contract directly with providers in the event no contracted health plan is willing to provide an adequate provider network.
- Allows HCG to contract with commercial insurers.
- Allows HIFA parents of Medicaid/SCHIP children who participate in the Premium Assistance Program (see next section) to enroll in HCG.
- Allows uninsured persons who lost their jobs due to foreign trade and qualify for federal tax credit for health insurance to enroll in HCG (coverage option permitted under Trade Act of 2002).
- Allows HCG to pay insurance brokers/producers a one-time enrollment commission.
- Requires small business to go bare for 180 days to be eligible to enroll in HCG.
- Prohibits HCG and its plans from using the AHCCCS fee-for service rates for hospitals as a default rate.[42]

In order to further support the State's commitment to use HCG as a key strategy for reducing the number of uninsured, AHCCCSA recently received a one year HRSA State Planning Continuation Grant. As part of this project, AHCCCSA plans to:

- Conduct focus groups to gain a more thorough and detailed understanding of the characteristics and needs of the working uninsured in Arizona.
- Prepare a policy brief on the utilization patterns and service demands of the newly insured as gleaned from other national data and studies.
- Conduct a thorough evaluation of HCG and its impact on reducing the number of uninsured.

The information gathered through these efforts will allow AHCCCS to better develop strategies to both ensure HCG's self-sufficiency and to expand and improve HCG's ability to offer affordable health insurance options to Arizona's working uninsured.

Premium Assistance Program (or Employer-Sponsored Insurance)

"Development of private-public coverage programs such as premium assistance programs" was one of the selected coverage options in the Task Force plan. Given the looming state budget crisis, this type of approach was of particular interest to legislators as it was seen as a way to support coverage expansion without requiring additional state funds and as support for public-private partnerships for employer-based insurance. Additionally, as part of its HIFA waiver,

[42] The latter two provisions came about as part of the negotiations with the commercial insurers.

AHCCCSA agreed to explore the feasibility of implementing a premium assistance program (employer-sponsored program - ESI) in Arizona using Title XXI as matching federal funds.

The feasibility study, conducted by AHCCCSA was divided into three components:

- A review of critical background information, e.g., federal regulations, other states' experience and current data on the working uninsured and employer-based coverage in Arizona.
- Development of a basic premium assistance model that would work best within the context of the current AHCCCS program framework and effectively meet the needs of the population being served.
- An evaluation of the pros and cons of implementing the AHCCCS designed model.

In May 2002, a final report was submitted to CMS. While the report recognized the potential role that a premium assistance program could play in the development of an accessible and affordable health care coverage system in Arizona, it was recommended that such a program not be implemented in Arizona at this time. A principle concern was that the administrative effort and cost of implementing an ESI program did not offset the potentially small number of individuals that were expected to enroll in an ESI program. AHCCCSA decided that other efforts with Title XXI funding (e.g. expanding health care coverage to parents of Medicaid/SCHIP children) were more cost effective, reaching more needy, low-income individuals and more significantly reducing the number of uninsured in Arizona.

Despite these reservations, AHCCCSA subsequently agreed to work on designing and implementing a premium assistance program to be piloted in two counties. An internal work group was formed and charged with the task of designing a program. In February 2004, an Employer Sponsored Insurance (ESI) Pilot Program proposal was submitted to CMS for review. Some key design features include:

- Program would be piloted in two rural counties – Yavapai and Yuma. Selection was based on reasonable size of counties, presence of several major employers as well as a high proportion of small employers, ethnic diversity, and availability of Healthcare Group as an insurance product.
- Eligible population would be SCHIP eligible families who have a household income between 100 to 200% of FPL and who have access to qualified employer sponsored insurance coverage.
- Qualified employer sponsored insurance would include coverage provided through HCG or through any other commercial group package offered by the employers that covers basic primary care. There would be no wrap-around service provided by AHCCCS.
- Enrollment in the program would be optional, but once elected, persons would be locked-in for 12 months except under certain circumstances (e.g. no longer employed).
- While enrolled families would not have to make any contribution to premiums as they do when enrolling in AHCCCS, they would be responsible to pay for any cost sharing required by their employer-based plan.

- There would be both an interim and final program evaluation that would look at the cost effectiveness of the program.

AHCCCSA had planned to implement the program in July 2004; however, the proposal is still awaiting approval by CMS. Since the ESI program is tied to covering the HIFA II parent group (i.e., parents of Medicaid/SCHIP children), it is essential that AHCCCSA have the statutory authority to offer health care coverage to the HIFA II parents. The current authority expires June 30, 2005 and the legislature must pass legislation to extend the HIFA II program after that date. If the legislature does not extend the HIFA II group, the ESI program will not operate in this State.

Table 3: Update on Progress to Date on the Task Force Recommended Coverage Strategies

Task Force Recommendations	Progress to Date
I. Narrow the gap between existing public and private health coverage programs.	
▪ Insurance reform to promote more accessible and affordable coverage options, especially those targeted at individual / small group markets.	▪ See discussion on enhancements to Healthcare Group. ▪ In 2003, Department of Insurance was given the legislative authority to improve rate stability in the long term care insurance market, including the authority to approve and disapprove rates and regulate non-forfeiture benefits associated with long term care insurance.
▪ Consumer and employer education initiatives on the value of health care coverage and existing options within the private marketplace.	▪ AHCCCS assisted St. Luke's Health Initiative in developing materials to share with small businesses to inform them of products available via public and private companies. This information is also published on their website.
▪ Private-public coverage programs such as high risk pool, full cost buy-in program or a premium assistance employer buy-in program.	▪ See discussion on design of premium assistance program. ▪ One Task Force member explored a full cost buy-in to AHCCCS for small size businesses. Using the Medicaid benefit package, sample rates for two small group health plans models with different co-payment levels were developed. With the Task Force member's retirement from the Legislature, this issue was not pursued.
▪ Program for cooperative purchase of employee healthcare benefits by small group employers.	No activity.

Table 3: Update on Progress to Date on the Task Force Recommended Coverage Strategies

Task Force Recommendations	Progress to Date
II. Restructure current state employee and retiree health care coverage programs (e.g., self-insurance system and expansion of pool size).	
	▪ On October 1, 2004, the state moved to a self-insurance health benefit plan for current state employees and retirees. The new program is expected to save the State up to $40 million dollars over the next 5 years. In addition, annual premiums have remained the same for the HMO-like product and have been reduced by 30% for the PPO product. No increases were made to employee cost sharing requirements. ▪ 2004 legislation allows school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities or public entities organized according to the laws of the State to apply to participate in the self-insurance program.
III. Enhance existing public supported programs[43]	
▪ Support of effective outreach programs.	▪ Beginning October 2001, AHCCCS applicants were no longer required to come for face-to-face interview. ▪ Covering Kids Arizona, a RWJ project, is supporting state pilot projects related to community outreach and enrollment. ▪ AHCCCSA is implementing a Health-e-App program, an online application designed to enroll low-income families in AHCCCS programs and streamline enrollment. This will be available at all FQHCs. ▪ AHCCCSA has partnered with the Department of Education to notify families of the KidsCare program through the Child Nutrition Program.

[43] .This is one of AHCCCS' specific strategies for meeting goal to reduce uninsured rate.

Table 3: Update on Progress to Date on the Task Force Recommended Coverage Strategies

Task Force Recommendations	Progress to Date
	▪ Arizona Community Action Association has created the Arizona Self Help Web site which can prescreen eligibility for social service programs such as AHCCCS. Similar information on eligibility has also been made available on the Arizona Association for Community Health Center's Web site.
▪ Coverage of parents of Title XXI children expansion of coverage groups.	▪ AHCCCSA received a HIFA waiver in December 2001 allowing the State to used Title XXI monies to expand coverage to parents of Title XIX/XXI children. The program was implemented in October 2002 and currently has over 11,000 parents enrolled. ▪ Current State law repeals coverage of HIFA eligible parents on July 1, 2005. In spring 2004, AHCCCSA surveyed eligible parents to determine who they are (e.g., education level, where live, hours work, etc). This data is currently being analyzed and will used to educate legislators about this group and their need for coverage.
▪ Development of a plan to expand Title XIX coverage groups through state plan amendments.	▪ In 2001, AHCCCSA expanded coverage for uninsured women with breast/cervical cancer. ▪ In 2002, AHCCCSA expanded coverage to workers who meet SSI disability requirement and have incomes below 250% FPL (i.e., Ticket to Work).
IV. Improve the rural health care infrastructure through a variety of strategies.	
▪ Continuing to support safety-net providers.	▪ AHCCCSA has actively participated in the development of HealthCare Connect, a public-private partnership in Maricopa County that connects low-income uninsured person with health care at affordable rates.
▪ Fostering volunteerism and engaging the services of retirees from the health care professions.	No activity
▪ Encouraging competition between health care service providers.	▪ With increasing health care manpower shortages; the focus of the State has been on developing strategies to maintain and enhance the current infrastructure.
▪ Increasing accessibility to medical services.	▪ AHCCCS completed two separate studies related to rural health care

Table 3: Update on Progress to Date on the Task Force Recommended Coverage Strategies

Task Force Recommendations	Progress to Date
	and its infrastructure (see discussion in Section 3). ▪ 2002 legislation established the Rural Physician Study Committee to examine the issue of malpractice and its impact on physicians practicing in rural areas of the State. ▪ University of Arizona Medical School is developing a plan to address physician shortages. ▪ University of Arizona Rural Health Office is developing a statewide rural health plan to improve health care in rural areas of the State. ▪ Arizona's telemedicine program has continued to expand; since 2000, 30 more sites have been added. ▪ AHCCCS is working with the Arizona State University, W.P. Carey School of Business, Center for Business Research to conduct an assessment of Community Health Centers in Arizona to develop business and practice management models that will attract a more diverse patient population and improve financial viability. Data is also being analyzed that will identify geographic zones in which the patient capacity and health care dollars are present to support new or expanded local health care delivery sites (public or private).
▪ Developing a plan to more effectively coordinate current rural health care resources and programs.	▪ The Arizona Healthcare Provider Recruitment and Retention Partnership was recently formed to develop a proposal that addresses health care workforce issues within Arizona's medically underserved communities. The collaboration includes: AHCCCSA, the Arizona Association of Community Health Centers, Arizona Area Health Education Centers Program, Arizona Department of Health Services, Arizona Hospital and Healthcare Association and the Arizona Community College Association.

SECTION 5. CONSENSUS BUILDING STRATEGIES

This section describes the governance structure, including methods used to obtain input from stakeholders and other activities conducted to build public awareness and support. Additionally, this section provides a brief overview of the current "policy environment" as it impacts the implementation of coverage expansion options.

Governance Structure

The Governor of Arizona identified AHCCCSA, the state's Medicaid/SCHIP agency and overseer of Healthcare Group, as the lead project agency for the project. While AHCCCSA has remained the responsible agency for guiding and overseeing the grant activities, elements of the governance structure were modified between Phases I and II, to better meet the needs of the defined project goals for those phases.

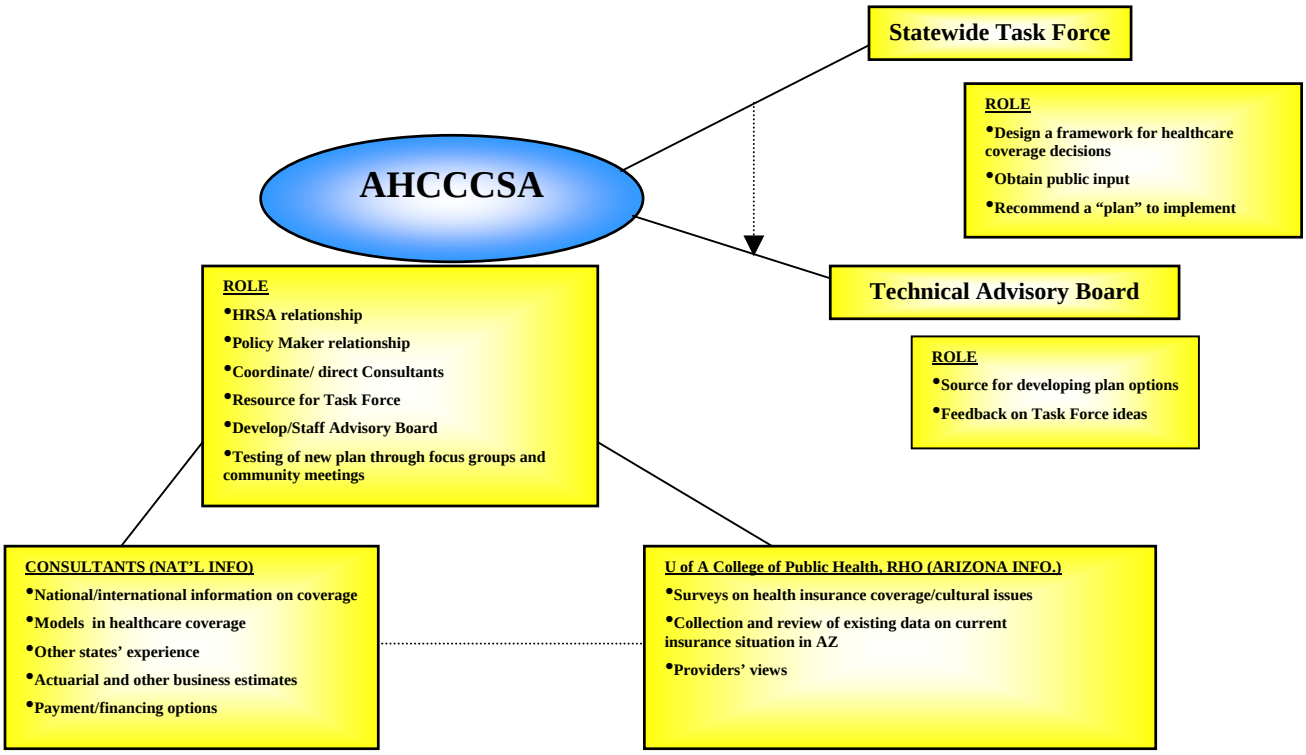
Phase I: Development of General Plan for Coverage of Uninsured

During Phase I, the governance structure AHCCCSA put in place lent itself to a process by which one was able to effectively build consensus around a coverage expansion plan, to address the issue of the uninsured in Arizona. The governance structure ensured involvement of the executive branch, the legislative branch, and a variety of key constituent groups in the planning process. A schematic of the organizational structure is set forth in Diagram 2 on next page. Key components include:

- AHCCCSA Team. The AHCCCS Director, served as the principal investigator for the project with other relevant AHCCCS staff included as part of the project team (e.g., administrator of the policy unit and the medical director). In addition to appointing a current staff person as the AHCCCS-HRSA Coordinator, two (2) new positions were established – a project administration associate and a provider relations/model development specialist. Aside from AHCCCSA staff, AHCCCSA contracted with an outside consultant to serve as the Project Director and another to serve as a facilitator for various project related meetings, e.g., Task Force meetings.

- Task Force. The Statewide Health Care Insurance Plan Task Force was a legislatively sponsored committee, charged with the responsibility of designing an accessible and affordable health care coverage plan; including the identification of recommended strategies to be implemented. There were six (6) legislators on this committee representing both rural and urban districts in the State. In addition, other key constituent groups represented on the Task Force included a health care provider, a representative of a consumer advocacy group and a representative of the business community. These three (3) members were appointed by the Governor.

Diagram 2: Project Schema HRSA for Phase I



The Task Force held numerous meetings for which AHCCCSA played a lead role in the provision of technical assistance and staffing support. These meetings served multiple functions, allowing Task Force members to hear formal presentations by experts in the community, to receive public testimony and to discuss key issues and solutions related to the provision of accessible and affordable health care coverage in Arizona. Two key outcomes from these meetings were (see Section 4):

- The development of an agreed upon set of basic principles for health care coverage in Arizona which are intended to serve as the framework for guiding the Task Force in the formulation of final recommendations.
- Final recommendations that included a General Plan for coverage of the uninsured and supported proposed changes to Healthcare Group.

- Technical Advisory Committee (TAC). AHCCCSA created the TAC to serve in an advisory capacity to both AHCCCSA and the Statewide Health Care Insurance Plan Task Force; providing guidance in the development of the General Plan as well as feedback on proposed approaches. The TAC was composed of representatives from the physician community, insurance companies (urban/rural, commercial and specialty), hospitals (rural and urban) and state agency directors of AHCCCSA and the Department of Insurance. The TAC primarily focused on the development of strategies that "use available, affordable, financial insurance vehicles to reduce the uninsured population that

would not be eligible for public programs." Strategies they recommended to the Task Force included:

- Community-based education on the value of insurance.
- A High-risk pool using multiple funding sources (e.g., public, private and insurance premium funded).
- Ability to market flexible benefit packages that could be adapted to current marketplace demands.

Phase II: Development of Specific Coverage Options

For Phase II of the project, the organizational structure was simplified. While the key AHCCCSA SPG project staff continued to be actively involved in the project, there was more limited use of consultants with much of the work being accomplished by qualified internal AHCCCSA staff. The Technical Advisory Committee was disbanded as the new Task Force expanded its representation to include representatives from similar organizations.

AHCCCSA was fortunate in having a formalized body of decision-makers in the newly reestablished legislatively task force (i.e., Statewide Health Care Insurance Plan Task Force). As in Phase I, the Task Force was helpful in moving forward the planning efforts for addressing the issue of accessible and affordable health insurance for all Arizonans. The Governor also played a key role in ensuring the passage of needed legislation to reform Healthcare Group and continue coverage of parents of Medicaid/SCHIP children (i.e., HIFA parents).

Stakeholder Input

Phase I: Development of General Plan for Coverage of Uninsured

In addition to the various constituent groups that were part of the governance structure, the Task Force provided a number of opportunities for the public to participate in the planning process. In addition to the State Planning Grant-related presentations, numerous other formal presentations were made by other local health care experts, e.g., on telemedicine and on the state employee insurance plan. All the Task Force meetings were well attended (i.e., approximately 50 attendees) with representatives from insurance carriers, retirement groups, advocacy agencies, employee unions, hospital association, health facilities and county governments. Additionally, numerous stakeholders provided public testimony including representatives from:

- Arizona Bridge to Independent Living
- American Association of Retired Persons
- Arizona Citizen Act
- Community Physicians
- Arizona Pharmacy Association
- Arizona Interfaith / Valley Interfaith

Phase II: Development of Specific Coverage Options

During the second phase of the project, AHCCCSA actively solicited input from targeted stakeholder groups regarding the specific coverage option under consideration:

- AHCCCSA conducted extensive interviews with rural health care practitioners around the State to identify barriers that discourage providers from practicing in rural areas as well as effective strategies for further developing the rural provider network and expanding coverage to those in need.
- In order to further refine proposed HCG benefit packages and better understand issues of affordability for small businesses, meetings were held with community interest groups (e.g., Hispanic, Asian, and Afro-American business groups, local chambers of commerce, and credit unions).

Other Public Awareness Strategies

In order to facilitate the public's easy access to AHCCCS-HRSA State Planning Grant information and project materials, AHCCCSA established and has continued to maintain a website (see http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp). This website contains general descriptive information about the project, Technical Advisory Committee minutes, the policy issue papers, Task Force guiding principles, project contacts and links to state/federal related Web sites.

In addition to the establishment of the website, AHCCCSA made numerous public presentations regarding the AHCCCSA-HRSA State Planning Grant. This included presentations at the Arizona Rural Health Conference, Arizona Community Access Program meeting, local Employee Benefit Research Institute - Consumer Health Education Council meeting on small group market, HRSA State Planning Meetings, AcademyHealth conference, Healthcare Financial Management Association conference, and the American Association of Healthcare Administrative Management conference.

AHCCCSA also ensured direct lines of communication with other entities/organizations with overlapping interest, e.g., Community Access Program grantees; St Luke's Initiative and Collaboration for a New Century – Health Coverage Options Subcommittee. The health Coverage Options Subcommittee is using the work of the State Planning Grant to move forward their agenda to promote outreach and education, insurance for small-business and state employee insurance reform.

Current "Policy Environment"

The slowly recovering economy and the ongoing rise in health care costs continue to significantly impact the type of coverage expansion strategies that realistically will be adopted in the State in the near future. In fact, the biggest challenge for the State in recent years has been to

maintain the coverage expansion efforts that were successfully implemented in previous years when the State's economy was thriving. While efforts to date have been successful in keeping the major program expansion initiatives, (e.g., HIFA eligible parents) some smaller programs have been eliminated or restricted (e.g., the Premium Sharing Program was repealed, with approximately 3,300 individuals losing coverage, eligibility for pregnant women was lowered from 140% of FPL to 133%, amount of tobacco tax monies used to support a variety of safety net programs was reduced). Given the current lack of support for large-scale state-supported expansion efforts, further development of creative private public partnerships such as the Maricopa project and Healthcare Group have become critical to address the needs of the uninsured.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Overall, AHCCCSA found the State Planning Grant to be an effective means for guiding and enhancing the State's policy discussion related to addressing the need for accessible and affordable health care coverage in Arizona. The end result of this effort was:

- An increased understanding of the issues surrounding health care coverage and the uninsured in Arizona.
- Development of a general framework within which to work on the development of specific policy options.
- Support to continue to further develop specific options, especially Healthcare Group.

This section discusses some of the lessons learned by Arizona through its State Planning Grant process, including recommendations to other states regarding the policy planning process itself.

Data Collection Lessons

The State believes it was effectively able to achieve its initial project goals by relying on secondary data sources during the initial phase of its planning process. Through the compilation of this data on the uninsured and coverage in Arizona the State was the able to educate policymakers about the uninsured in Arizona and coverage issues and facilitate the development of a general coverage plan for the State. Additionally, this approach cost substantially less and required less time in its compilation than what would have been require by the collection of primary data (e.g., household surveys, and focus groups).

This same approach, however, has not proven to be as useful in the subsequent development of specific coverage options. The available secondary data is simply not able to provide the level of detail needed to be able to make well informed decisions as to how best to design and implement agreed upon coverage and expansion strategies. For example, county-specific information on the number of uninsured by county would have been useful in deciding which counties to select for the premium assistance pilot program and developing affordable small group products that would appeal to low-income individuals would be easier if information was readily available on the characteristics of the uninsured who are employed at small size firms both at a state level as well as county level. Now that the State has more clearly defined the strategies it wants to pursue in terms of coverage expansion, the State can effectively target its primary data needs to support these efforts. To that end, through the recently awarded State Planning Continuation Grant, AHCCCSA plans to conduct a series of focus groups to obtain a more in-depth understanding of the working uninsured.

Organization and Consensus Building Lessons

AHCCCSA believes the project organizational structure that it put in place for the initial planning effort was very effective in achieving the project goals. Due to the complex nature of the subject, education of the Task Force members as well as the public prove to be a critical component in developing the General Plan for coverage of the uninsured. The approach of using both a legislative-based Task Force and the Technical Advisory Committee provided a good balance between the political decision-making process and more expertise-based decision making. Having the legislative involvement from the beginning also made it much easier to get immediate support for continuing the planning effort beyond the grant period and to ensure passage of legislation which supported the Task Force recommendations.

While there was little resistance by stakeholder groups to the high-level strategies proposed by the Task Force for addressing accessible and affordable coverage in the State, the further development of specific options clearly requires greater effort devoted to building the stakeholder support necessary to ensure final implementation of the efforts. This was demonstrated recently in the struggle AHCCCSA faced in trying to get legislation passed to support efforts to increase HCG's role in addressing uninsured workers (e.g., commercial insurer's launched a campaign against the proposed changes.) Only through the active involvement of the Governor and key policymakers in the Legislature, continued support of HCG members and providers, and a series of meetings with concerned stakeholder groups was AHCCCSA able to achieve resolution and final passage of the legislation.

Recommendations Related to Policy Planning Process

Other recommendations related to the policy planning process AHCCCSA believes are important for states to consider include:

- Prior to determining information to be collected or issues to be researched, conduct a thorough-review of the information (e.g., reports, surveys) that is already available both nationally and locally. There is a surprising amount of data and information out there on the subject, some of which has simply not been well publicized.
- Take advantage of the technical resources that are available through the State Planning Grant (e.g., Academy for Health Services Research and Health Policy, State Health Access Data Assistance Center) as well as the knowledge and work of the other State Planning Grant states.
- Be realistic about what one can accomplish in a year, everything takes longer than expected. For Arizona, it took the entire year just to develop a General Plan and that was without doing any primary data collection.
- Be sensitive to the political climate, adjusting project goals to accommodate changes in the policy-making environment.
- Think carefully about what data is really needed to support the planning effort. There is an abundance of information that is "nice" to know but may not be directly helpful in furthering the State's planning efforts.

- Consider a multi-year phase-in rather than tackling the entire problem of the uninsured all at once.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

It is important for the Federal government to continue to work in partnership with the states in the development of effective strategies for addressing the uninsured. In this partnership, the Federal Government should:

- Allow states more flexibility in the design and operation of Medicaid and SCHIP. This is particularly the case with options such as premium assistance programs whose potential effectiveness is severely hindered by federal regulation.
- Provide federal financial support for coverage expansions such as subsidies for low-income individuals.
- Expand the level of state specific information that is collected by the Federal Government on coverage related issues, ensuring the information is timely and readily accessible to the states.
- Continue to fund state research on the uninsured including the development of strategies to prevent erosion of current coverage programs given the current economic environment. Additionally, previously funded SPG states should be allowed and encouraged to participate in the HRSA-sponsored SPG conferences.
- Consider funding a similar program on the issue of the growing number of "underinsured elderly" who are in need of long term care services.

Only with a strong federal-state partnership will the issue of health care coverage in Arizona and the nation as a whole be effectively addressed.

APPENDIX I: BASELINE INFORMATION

Population

Arizona's estimated population for 7/1/2003 was 5,629,870.[44] Looking at previous growth trends, AHCCCSA has projected Arizona's 2004 population at around 5.8 million.

Number and Percentage of Uninsured (Current and Trend)

According to the U.S. Census Bureau 2004 Current Population Report, Arizona's overall rate of uninsurance was 16.9%[45]. After decreasing substantially between 1998 and 2000, the number of uninsured in Arizona for all ages appears to have plateaued (see Table 1).

Average Age of Population

As reported by the American Community Survey Profile 2003, the median age in Arizona was 33.9 years.[46] Twenty-eight percent of the population were under 18 years and 13% were 65 years and older.

Percent of Population Living in Poverty (<100% of FPL)

In 2003, according to the American Community Survey Profile, 15% of Arizonans were below poverty level (i.e., incomes less than 100% of FPL).[47] Further broken down:

- 21% of related children under 18 below the poverty level,
- 8% of people age 65 and over below poverty level
- 12% of all families below poverty level
- 31% of female householder families below poverty level.

Primary Industries

In 2003, according to the American Community Survey Profile, for the employed population 16 years and older, the leading industries in Arizona were:[48]

[44] Arizona Department of Economic Security, Population Statistics Unit, Research Administration. http://www.workforce.az.gov. 2004 estimates will not be out until February 2005.
[45] This is based on a 2 year average 2002 – 2003. See *Health Insurance Coverage: 2003 Consumer Income* Current Population Reports by Robert J. Mills from U.S. Census Bureau (Issued August 2004); available from www.census.gov.
[46] U.S. Census Bureau. American Community Survey Profile 2003. http://www.census.gov/acs.
[47] Ibid
[48] Ibid

- Education, health and social services (19%);
- Retail trade (13%); and
- Leisure and hospitality; and professional and business services (each at 10%).

Seventy-eight percent of the people employed were private wage and salary workers, 16% were government workers and 6% were self-employed. The three most common occupations were: management, professional and related occupations (34%); sales and office occupations (27%) and service occupations (18%).

Number and Percent of Employers Offering Coverage

The 2002 Medical Expenditure Panel Survey – Insurance Component reported, there were 101,318 private-sector establishments in Arizona of which 52.4% (53,090) offered health insurance.[49] For firms with less then 50 employees, only 36.4% of the establishments offered health insurance and for firms with 50 or more employees, 95.7% offered health insurance.

Number and Percent of Self-Insured Firms

The 2002 Medical Expenditure Panel Survey – Insurance Component reported there were 101,318 private-sector establishments in Arizona, of which 33.8% (34,245) offered health insurance that self-insure at least one health insurance plan.[50]

Payer Mix

The pooled 2002 and 2003 Current Population Surveys showed the population distribution by insurance status (i.e., payer mix) for Arizona as:[51]

- 53% - Employer
- 6% - Individual
- 11% - Medicaid (based on current AHCCCS enrollment, the percentage is now around 17%)
- 13% - Medicare
- 17% - Uninsured

Provider Competition

Arizona's rapid population growth is placing significant pressure on its current health care infrastructure, leading to provider shortages and reduced provider competition in many areas of the State (see Section 3 under Health Care Infrastructure). While costs for premiums has escalated over the last few years, the number of health plans participating in the group market as well as in AHCCCS and Medicare+Choice has remained relatively stable. The urban areas of

[49] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2002 Medical Expenditure Panel Survey – Insurance Component. www.meps.ahrq.gov.
[50] Ibid.
[51] Kaiser Family Foundation. State Health Facts Online. Arizona: http://www.statehealthfacts.org.

the State afford consumers both a larger choice of plans and products, with many rural parts of the State being dominated by a single plan and limited to non-HMO coverage options.

The Winter 2001 and Summer 2003, *Community Tracking Reports*[52] reported on emerging provider trends among hospitals, physicians, and health plans in the Phoenix market, much of which is applicable to the State as a whole.

- National firms now control the majority of the Phoenix community's hospital capacity and dominate the health plan market. Banner Health accounts for about 37% of inpatient discharge and 5 of the 15 Vanguard Health owned hospitals are in Phoenix. These firms are building new hospitals to vie for position in the rapidly growing Phoenix metropolitan area.
- Hospitals are developing specialty hospitals to compete with a growing number of physician-owned specialty facilities in Phoenix.
- With provider capacity failing to keep pace with population growth, providers are more willing to walk away from contracts that do not pay what they want, making it more difficult for health plans to negotiate smaller payment increases, particularly with hospitals.

Insurance Market Reforms

Health care insurance reforms that have occurred in Arizona over the past 10 years include:

- In 1993, the legislature enacted the Accountable Health Plan Law, which was aimed at improving the availability of group health insurance to small-employers. Effective January 1, 1994, group health insurers (Accountable Health Plans) were required to offer at least a basic health benefits plan to employers, including small-employers. The legislation phased in elements of guaranteed issue with later effective dates. Specifically, effective July 1, 1994, an Accountable Health Plan was required to make the basic health benefits plan available to employers with 25 to 40 employees who had been without coverage for at least 90 days. Effective July 1, 1996, an Accountable Health Plan was required to make the basic health benefits plan available to employers with three (3) to 40 employees who had been without coverage for at least 90 days.

- While the 1993 legislation improved the availability of group health insurance to small-employers, it only provided such coverage on a guaranteed issue basis for certain small-employers and their employees. Legislation that became effective July 1, 1997 required an Accountable Health Plan to provide a health benefits plan, without regard to health status-related factors, to any small-employer who agreed to make the required premium payments. As part of this legislation, the definition of "small-employer" was revised to include any employer with two (2) but not more than 50 employees, the basic health benefit plan was eliminated and all small-employers are entitled to guaranteed issue, not

[52] Center for Studying Health System Change. http://www.hschange.org.

just those that have been without coverage for at least 90 days. This legislation conformed to federal guaranteed availability requirements established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- In 1996, another aspect of small-employer market reform was enacted, granting a premium tax exemption for Accountable Health Plans for reported small group premiums. (All insurers in the State, including Accountable Health Plans must pay a two percent tax on their premiums). Some Accountable Health Plans have determined that the tax savings is not worth the administrative cost of breaking out the small-employer premiums and do not claim the exemption.

- In 2000, the Arizona legislature passed legislation restructuring the regulatory oversight of managed care organizations, with DOI having oversight of medical service delivery by HMOs and dental service delivery by prepaid dental plan organization, mandating additional health care benefits (e.g., off label use of drugs for cancer treatment, direct access to chiropractic services) and establishing timely pay and grievance standards for payment of health care providers.

- In 2003, DOI was given the legislative authority to improve rate stability in the long term care insurance market, giving DOI the authority to approve and disapprove rates and regulate non-forfeiture benefits associated with long term care insurance.

Eligibility for Existing Coverage Programs

See Diagram 3 on next page for eligibility levels for income-based AHCCCS programs:[53]

[53] Current Federal Poverty Levels means a family of 4 at 100% of FPL earns $18,852 annually; a single individual at 100% of FPL earns $9,312 annually

Diagram 3: Eligibility Levels for AHCCCS Programs

Young Adult Transitional (18 – 21 years who were children in foster care when they turned 18; no income limit)				--No Income Limit
Ticket to Work (limited to disabled, 16 – 65 years, returning to work – allows them to retain Medicaid benefits)		Breast and Cervical Program (under 65 and ineligible for other forms of Medicaid)		--250% FPL
Arizona Long Term Care Program [300% of Federal Benefit Rate (equivalent to 218% FPL) and at risk for institutionalization]				--218% FPL
Title XXI (SCHIP): ▪ KidsCare (limited to children under 19 years) ▪ Parents of KidsCare or Title XIX children (limited to availability of funds)				--200% FPL
Transitional Medical Assistance (TMA)				--185% FPL
AHCCCS Medicaid – Children Under Age 1 (SOBRA)				--140% FPL
Medicare Cost Sharing Program (up to 135% of FPL depending on the program)				--135% FPL
AHCCCS Medicaid – Pregnant Women and Children Ages 1 – 5 (SOBRA)				--133% FPL
AHCCCS Medicaid – Various Programs Based on Income (Prop 204/Title XIX Wavier)	Families and Children 1931	AHCCCS Medicaid – Children Ages 6 - 18	Supplemental Security Income (SSI) Limited	--100% FPL
AHCCCS Medicaid – Spend-down group (medical expense reduce gross income to 40% of FPL)				--40% FPL

Use of Federal Waivers

Arizona became the last state in the nation to implement a Medicaid program. In October 1982, Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS) was started under an 1115 Research and Demonstration Waiver granted by the Health Care Financing Administration (HCFA). The following Medicaid services were phased-in between 1982 and 1990:

- From 1982 until 1988, AHCCCS only covered acute care services, except for a 90-day, post-hospital skilled nursing facility coverage.

- In 1988, a five (5) year extension of the program was approved by HCFA to allow Arizona to implement a capitated long-term care program called the Arizona Long Term Care System for the elderly, physically disabled, and developmentally disabled populations.
- In 1990, AHCCCS began offering comprehensive behavioral health services, eventually extending behavioral coverage to all Medicaid eligible persons over the next five (5) years.

Since 1990, a number of waiver extensions and amendments have been approved.

- In January 2001, coverage under Title XIX was expanded to include individuals with income at or below 100% of FPL and individuals who incur medical bills sufficient to reduce their income to 40% of FPL. The approved waiver amendment was the result of a ballot initiative.
- In December 2001, the demonstration waiver was extended until September 30, 2006.

A Health Insurance Flexibility and Accountability (HIFA) waiver was approved by the Center for Medicare and Medicaid Services (CMS) in 2002 allowing:

- Coverage of parents of Medicaid and SCHIP children with family incomes between 100 to 200% of FPL (implemented October 1, 2002).
- Limited approval to use Title XXI funds for adults over 18 without dependent children with income at or below 100% of FPL. The State may only use the Title XXI funds for the expansion population as long as sufficient Title XXI funding is available for SCHIP children and parents.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

The key Web Site to use for additional sources of information regarding the AHCCCS-HRSA State Planning Grant is http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp.

In addition for more information about Healthcare Group of Arizona (HCG) use the HCG Web Site at http://www.healthcaregroupaz.com.